State Health Benefit Plan – OAP Plan

OPEN ACCESS PLUS MEDICAL BENEFITS

EFFECTIVE DATE: January 1, 2009

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This document printed in May, 2009 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

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CIGNA HealthCare

Important Information

THIS IS NOT AN INSURED BENEFIT PLAN. THE BENEFITS DESCRIBED IN THIS BOOKLET OR ANY RIDER ATTACHED HERETO ARE SELF-INSURED BY STATE HEALTH BENEFIT PLAN WHICH IS RESPONSIBLE FOR THEIR PAYMENT. CONNECTICUT GENERAL PROVIDES CLAIM ADMINISTRATION SERVICES TO THE PLAN, BUT CONNECTICUT GENERAL DOES NOT INSURE THE BENEFITS DESCRIBED.

THIS DOCUMENT MAY USE WORDS THAT DESCRIBE A PLAN INSURED BY CONNECTICUT GENERAL. BECAUSE THE PLAN IS NOT INSURED BY CONNECTICUT GENERAL, ALL REFERENCES TO INSURANCE SHALL BE READ TO INDICATE THAT THE PLAN IS SELF-INSURED.

ALL REFERENCES TO CG, CGLIC AND CONNECTICUT GENERAL ARE USED INTERCHANGABLY WITH CIGNA HEALTHCARE.

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Introduction

This booklet is your Summary Plan Description (SPD) and describes the provisions of your Open Access Plus Medical Benefits under the State Health Benefit Plan (SHBP), which is also referred to in this booklet as the "Plan." Use this SPD as a reference tool to help you understand the Plan and maximize your coverage.

The SHBP is a self-insured Plan, which is governed by the regulations of the Department of Community Health (DCH) Board, Chapter 111-4-1 Health Benefit Plan. If there are discrepancies between the information in this SPD and DCH Board regulations or the laws of the state of Georgia, those regulations and laws will govern at all times.

This booklet is notice to all Members of the SHBP's eligibility requirements and benefits payable for services provided on or after January 1, 2009, unless otherwise noted. Any and all statements to Members or to Providers about eligibility, payment or levels of payment that were made before January 1, 2009 are canceled if they conflict in any way with the provisions described in this booklet.

The SHBP reserves the right to act as sole interpreter of all the terms and conditions of the Plan, including this booklet and the separate medical policy guidelines that serve as supplement to this booklet to more fully define eligible charges.

The SHBP also reserves the right to modify its benefits, level of benefit coverage and eligibility/participation requirements at any time, subject only to reasonable notification to Members. When such a change is made, it will apply as of the modification's effective date to any and all charges incurred by Members on that day and after, unless otherwise specified by the DCH.

The Summary Plan Description published by CIGNA Healthcare for Members enrolled in the SHBP does not constitute a contract. The provisions of the program are subject to annual review and modification. Costs may vary each year.

How to Use this Document

We encourage you to read your SPD.

We especially encourage you to review the benefit limitations of this SPD by reading **The Schedule** and **Exclusions**. You should also carefully read the section titled **Federal and Other General Legal Requirements** to better understand how this SPD and your benefits work. You should call CIGNA Healthcare if you have questions about the limits of the coverage available to you.

Many of the sections of the SPD are related to other sections of the document. You may not have all of the information you need by reading just one section. We also encourage you to keep your SPD and any attachments in a safe place for your future reference.

Please be aware that your Physician does not have a copy of your SPD and is not responsible for knowing or communicating your benefits.

Information about Defined Terms

Because this SPD is a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the section titled **Definitions**. You can refer to the **Definitions** sections as you read this document to have a clearer understanding of your SPD.

When we use the words "we", "us", and "our" in this document, we are referring to SHBP. When we use the words "you" and "your" we are referring to people who are Covered Persons.

Fraud and Abuse

Please notify the Plan of any fraudulent activity regarding Plan Members, providers, payment of benefits, etc. Call 1-800-633-8519.

Your Contribution to the Benefit Costs

The Plan may require the Member to contribute to the cost of coverage. Contact your benefits representative for information about any part of this cost you may be responsible for paying.

Customer Service and Claims Submittal

Please make note of the following information that contains CIGNA Healthcare department names and telephone numbers.

Customer Service Representative (questions regarding Coverage or procedures):

Active Members 1-800-633-8519
Retiree Members 1-800-942-6724
Monday – Friday: 8:00 a.m. – 8:00 p.m.

Pre-Admission Certification:

Active Members 1-800-633-8519
Retiree Members 1-800-942-6724
For detailed explanation on Pre-Admission Certification/Continued Stay Review please see page 23.

Mental Health/Substance Abuse Services:

Active Members 1-800-633-8519
Retiree Members 1-800-942-6724

Pharmacy Services:

Active Members 1-800-633-8519
Retiree Members 1-800-942-6724

Written appeals and inquiries related to the Prescription Drug Program should be directed to:

CIGNA Healthcare
P.O. Box 188050
Chattanooga, TN 37422-8050

CIGNA Vision Services:

CIGNA Vision Claims Department
P.O. Box 997561
Sacramento, CA 95899-7561

Plan's Eligibility Unit:

404-656-6322, Atlanta
800-610-1863, toll-free outside Atlanta
Monday-Friday: 8:30 a.m. to 4:30 p.m.

Membership Correspondence for non-claim/eligibility issues:

State Health Benefit Plan
Membership Correspondence Unit
P. O. Box 1990
Atlanta, GA 30301-1990

Note: SHBP handles all eligibility appeals. All Member correspondences sent to the Plan (including SHBP forms and Medicare Part D ID card copies) should include the Member's Social Security Number (SSN) to prevent a delay in processing your requests.

Explanation of Terms

You will find terms starting with capital letters throughout your certificate. To help you understand your benefits, most of these terms are defined in the Definitions section of your certificate.

The Schedule

The Schedule is a brief outline of your maximum benefits which may be payable under your insurance. For a full description of each benefit, refer to the appropriate section listed in the Table of Contents.

Special Plan Provisions

Participating Providers include Physicians, Hospitals and Other Health Care Professionals and Other Health Care Facilities. Consult your Physician Guide for a list of Participating Providers in your area. Participating Providers are committed to providing you and your Dependents appropriate care while lowering medical costs. It is recommended that you verify that your physician is still a Participating Provider prior to each office visit.

Services Available in Conjunction With Your Medical Plan

The following pages describe helpful services available in conjunction with your medical plan. You can access these services by calling the toll-free number shown on the back of your ID card.

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CIGNA'S Toll-Free Care Line

CIGNA's toll-free care line allows you to talk to a health care professional during normal business hours, Monday through Friday, simply by calling the toll-free number shown on your ID card.

CIGNA's toll-free care line personnel can provide you with the names of Participating Providers. If you or your Dependents need medical care, you may consult your Physician Guide which is available on-line at myCIGNA.com and lists the Participating Providers in your area or call CIGNA's toll-free number for assistance. If you or your Dependents need medical care while away from home, you may have access to a national network of Participating Providers through CIGNA's Away-From-Home Care feature. Call CIGNA's toll-free care line for the names of Participating Providers in other network areas. Whether you obtain the name of a Participating Provider from your Physician Guide or through the care line, it is recommended that prior to making an appointment you call the provider to confirm that he or she is a current participant in the Open Access Plus Program.

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Case Management

Case Management is a service provided through a Review Organization, which assists individuals with treatment needs that extend beyond the acute care setting. The goal of Case Management is to ensure that patients receive appropriate care in the most effective setting possible whether at home, as an outpatient, or an inpatient in a Hospital or specialized facility. Should the need for Case Management arise, a Case Management professional will work closely with the patient, his or her family and the attending Physician to determine appropriate treatment options which will best meet the patient's needs and keep costs manageable. The Case Manager will help coordinate the treatment program and arrange for necessary resources. Case Managers are also available to answer questions and provide ongoing support for the family in times of medical crisis.

Case Managers are Registered Nurses (RNs) and other credentialed health care professionals, each trained in a clinical specialty area such as trauma, high risk pregnancy and neonates, oncology, mental health, rehabilitation or general medicine and surgery. A Case Manager trained in the appropriate clinical specialty area will be assigned to you or your Dependent. In addition, Case Managers are supported by a panel of Physician advisors who offer guidance on up-to-date treatment programs and medical technology. While the Case Manager recommends alternate treatment programs and helps coordinate needed resources, the patient's attending Physician remains responsible for the actual medical care.

1. You, your dependent or an attending Physician can request Case Management services by calling the toll-free number shown on your ID card during normal business hours, Monday through Friday. In addition, a claim office or a utilization review program (see the PAC/CSR section of your certificate) may refer an individual for Case Management.
2. The Review Organization assesses each case to determine whether Case Management is appropriate.
3. You or your Dependent is contacted by an assigned Case Manager who explains in detail how the program works. Participation in the program is voluntary - no penalty or benefit reduction is imposed if you do not wish to participate in Case Management.

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4. Following an initial assessment, the Case Manager works with you, your family and Physician to determine the needs of the patient and to identify what alternate treatment programs are available (for example, in-home medical care in lieu of an extended Hospital convalescence). You are not penalized if the alternate treatment program is not followed.
5. The Case Manager arranges for alternate treatment services and supplies, as needed (for example, nursing services or a Hospital bed and other Durable Medical Equipment for the home).
6. The Case Manager also acts as a liaison between the insurer, the patient, his or her family and Physician as needed (for example, by helping you to understand a complex medical diagnosis or treatment plan).
7. Once the alternate treatment program is in place, the Case Manager continues to manage the case to ensure the treatment program remains appropriate to the patient's needs.

While participation in Case Management is strictly voluntary, Case Management professionals can offer quality, cost-effective treatment alternatives, as well as provide assistance in obtaining needed medical resources and ongoing family support in a time of need.

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Additional Programs

We may, from time to time, offer or arrange for various entities to offer discounts, benefits, or other consideration to our Members for the purpose of promoting the general health and well being of our Members. We may also arrange for the reimbursement of all or a portion of the cost of services provided by other parties to the Policyholder. Contact us for details regarding any such arrangements.

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Well Aware Programs

Your benefit plan includes several programs to assist you with managing your healthcare and specifically for managing the following chronic conditions:

- Asthma;
- Low Back Pain;
- Cardiovascular Disease;
- Chronic Obstructive Pulmonary Disorder;
- Diabetes; and
- Depression.

Nurse Advice Line

You may call for professional medical advice regarding medical situations 24 hours a day, seven days a week. By calling this number, you can talk with a nurse who will assist you in making informed decisions about your health. For medical information and nurse assistance dial:

For Active Employees: 1- 800-633-8519; or
For Retired Employees: 1-800-942-6724.

Important Information About Your Medical Plan

Details of your medical benefits are described on the following pages.

You are not required to select a PCP.

Choice of Primary Care Physician:

This medical plan does not require that you select a Primary Care Physician or obtain a referral from a Primary Care Physician in order to receive all benefits available to you under this medical plan. Notwithstanding, a Primary Care Physician may serve an important role in meeting your health care needs by providing or arranging for medical care for you and your Dependents. For this reason, we encourage the use of Primary Care Physicians and provide you with the opportunity to select a Primary Care Physician from a list provided by CG for yourself and your Dependents. If you choose to select a Primary Care Physician, the Primary Care Physician you select for yourself may be different from the Primary Care Physician you select for each of your Dependents.

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How To File Your Out-of-Network Claim

The prompt filing of any required claim form will result in faster payment of your claim. All claims should be filed within 24 months from the date services are rendered.

You may get the required claim forms by visiting myCIGNA.com. All fully completed claim forms and bills should be sent directly to:

CIGNA Healthcare
P.O. Box 188050
Chattanooga, TN 37422-8050

Depending on your Group Insurance Plan benefits, file your claim forms as described below.

Hospital Confinement

If possible, get your Group Medical Insurance claim form before you are admitted to the Hospital. This form will make your admission easier and any cash deposit usually required will be waived.

If you have a benefit Identification Card, present it at the admission office at the time of your admission. The card tells the Hospital to send its bills directly to CG.

Doctor's Bills and Other Medical Expenses

The first Medical Claim should be filed as soon as you have incurred covered expenses. Itemized copies of your bills should be sent with the claim form. If you have any additional bills after the first treatment, file them promptly.

CLAIM REMINDERS

- BE SURE TO USE YOUR MEMBER ID AND ACCOUNT NUMBER WHEN YOU FILE CG'S CLAIM FORMS, OR WHEN YOU CALL YOUR CG CLAIM OFFICE.

  YOUR MEMBER ID IS THE ID SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.

  YOUR ACCOUNT NUMBER IS THE 7-DIGIT POLICY NUMBER SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.
- PROMPT FILING OF ANY REQUIRED CLAIM FORMS RESULTS IN FASTER PAYMENT OF YOUR CLAIMS.

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinement in prison.

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Eligibility — Effective Date

Who is Eligible for Coverage

Who	Description	Who Determines Eligibility
Eligible Person	You are eligible to enroll yourself and your eligible dependents for coverage if you are: ▪ **A Full-time employee of the State of Georgia, the General Assembly or an agency, board, commission, department, county administration or contracted employer that participates in SHBP, as long as:** – You work at least 30 hours a week consistently, and – Your employment is expected to last at least nine months. Not Eligible: Student employees or seasonal, part-time or short-term employees. ▪ **A certified public school teacher or library employee who works half-time or more, but not less than 17.5 hours a week.** Not Eligible: Temporary or emergency employees. ▪ **A non-certified service employee of a local school system who is eligible to participate in the Teachers Retirement System** or its local equivalent. You must also work at least 60% of a standard schedule for your position, but not less than 20 hours a week. ▪ **An employee who is eligible to participate in the Public School Employees' Retirement System** as defined by Paragraph 20 of Section 47-4-2 of the Official Code of Georgia, Annotated. You must also work at least 60% of a standard schedule for your position, but not less than 15 hours a week. ▪ **A retired employee of one of these listed groups** who was enrolled in the Plan at retirement and is eligible to receive an annuity benefit from a state-sponsored or state-related retirement system. See **Provisions for Eligible Retirees** for details of retiree medical coverage. ▪ **An employee in other groups** as defined by law.	SHBP determines who is eligible to enroll under the Plan.

Who	Description	Who Determines Eligibility
Dependent	Eligible dependents are: ▪ **Your legally married spouse; as defined by Georgia law.** ▪ **Your never-married dependent children who are:** 1. **Natural or legally adopted children under age 19,** unless they are eligible for coverage as employees. Children that are legally adopted through the judicial courts become eligible only after they are placed in your physical custody. 2. **Stepchildren under age 19 who live with you** at least 180 days per year and for whom you can provide documentation satisfactory to the Plan that they are your dependents. 3. **Other children under 19** if they live with you permanently and legally depend on you for financial support – as long as you have a court order, judgment or other satisfactory proof from a court of competent jurisdiction. 4. **Your natural children, legally adopted children or stepchildren 19 or older from categories 1, 2 and 3** above who are physically or mentally disabled and who depend on you for primary support . 5. **Your natural children, legally adopted children, stepchildren or other children age 19 to 26 from categories 1, 2 and 3** above who are registered full-time Students at fully accredited schools, colleges, universities, or nurse training institutions and, if employed, who are not eligible for a medical benefit plan from their employer. The number of credit hours required for full-time Student status is defined by the school in which the child is enrolled. You have 31 days from the date of your child's enrollment as a full-time student to add dependent coverage. You must also provide a completed Dependent Student Status Information form and full-time Student Verification from a fully accredited school, college, university, or nurse training institution. You will be required to provide copies of certified documents such as a marriage license, birth certificate, adoption contract or judge-signed court order to verify your dependent relationship. **Note: Coverage will not be updated until verification is approved. The Plan has the right to determine whether or not the documentation satisfies Plan requirements. Coverage will be updated from the qualifying event date or 1st day of current plan year, whichever is later.**	SHBP determines who qualifies as a Dependent.

Who	Description	Who Determines Eligibility
Dependent	**For a Covered Dependent age 19 & older…** ▪ … and a full-time Student under the age of 26: You must: ▪ update SHBP annually on student status by requesting a certification letter from the school's registrar and sending it attached to a Dependent Student Status Information Form to SHBP. The certification letter must include: - enrollment date(s) for both current and previous quarters or semesters; - number of credit-hours taken each quarter or semester; - enrollment status (full- or part-time) for each quarter or semester. Letters of acceptance can be submitted to temporarily extend coverage for students who graduate from high school in May and plan to attend college for the fall semester or students transferring between colleges. A Dependent Student Status Information form and certification letter must be submitted to provide coverage beyond the summer	SHBP determines who qualifies as a Dependent.
	For a Covered Dependent age 19 & older… ▪ … and disabled before age 26 You must: ▪ file a written request for continuation of coverage within 31 days of the 19th birthday to continue coverage if disabled prior to age 19 and dependent no longer meets the full-time student status requirement or within 31 days if disability occurs while covered as a full-time student after age 18 but prior to age 26. ▪ when requested by the Plan, re-certify your dependent(s). If you fail to re-certify your dependent within 31 days of the request, your dependent will no longer be eligible to be covered under the Plan until verification is received. **If documentation is received after 31 days, the plan will cover the dependent retroactively to the beginning of the current plan year or date of qualifying event, whichever is later, as long as the current tier premium is paid.** To enroll a disabled child as a new dependent, you must: ▪ make a request within 31 days of your hire date or qualifying event date; ▪ provide medical documentation that must be approved by the Plan; ▪ provide documentation that your child was disabled prior to age 26; and ▪ add the child during the Open Enrollment period.	

A general note regarding documentation sent to the Plan: SHBP requires that coverage requests are made within a specific time period and requires documentation to support the request. When SHBP requests documentation, if the documentation is not received within 31days of the SHBP request, the effective date of the coverage change will be the later of the qualifying event date or first day of the plan year, whichever is later.

Who's Not Eligible for Dependent Coverage

The most common examples of persons not eligible for SHBP dependent coverage include:

- Your former spouse
- Your fiancé
- Your parents
- Married or formerly married children
- Children age 19 or older who do not qualify as Full-time Students or disabled dependents
- Children in military service
- Grandchildren who cannot be considered eligible dependents
- Stepchildren who do not live in your home at least 180 days per year
- Anyone living in your home that is not related by marriage or birth, unless otherwise noted.

When to Enroll and When Coverage Begins

You *must* enroll to have SHBP coverage. To enroll, go to your personnel/payroll office for instructions. You will be asked to:

- Choose a coverage option;
- Choose a coverage tier; and
- Name eligible dependents you want to enroll and cover.

By enrolling this authorizes periodic payroll deductions for premiums. If you list dependent(s) you must elect a coverage tier that covers the dependent relationship to you. If you cover dependents and do not provide documentation to verify eligibility, you will be charged the tier you elected. Once dependents are verified the coverage will be effective from the date of the qualifying event or the 1st day of the current plan year, whichever is later. Please refer to "Who is eligible for coverage" for more information. Once you make your coverage election, changes are not allowed outside the Open Enrollment period, unless you have a qualified change in status under Section 125 of the Internal Revenue Code, which restricts mid-year changes to coverage in the SHBP. **Special Note: If you terminate employment and are re-hired by any employer eligible for the SHBP during the same Plan year, you must enroll in the same Plan option and tier, provided you are eligible for that option and have not had a qualifying event since coverage ended**.

If You Are Hospitalized When Your Coverage Begins

If you are inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, SHBP will pay benefits for Covered Health Services related to that Inpatient Stay from the effective date of coverage as long as you receive Covered Health Services in accordance with the terms of the Plan. You should notify CIGNA Healthcare within 48 hours of the day your coverage begins, or as soon as reasonably possible. In-Network benefits are available only if you receive Covered Health Services from Contracted providers.

Important Plan Membership Terms

The Plan uses these terms to describe Plan Membership:

- Member – You, the contract/policyholder
- Dependent – your eligible dependents that you choose to enroll

Where appropriate, this SPD relies on these terms throughout the document:

- Employee, Retiree or Member… to refer to Member
- Dependent(s)… to refer to Dependents

Note: Coverage is subject to pre-existing conditions and coverage limits (see page 80 for details). This limitation may not apply if you have creditable coverage (see page 85 for details).

DCH Surcharge Policy

Spousal Surcharge:

A spousal surcharge will be added to your monthly premium if you elect to cover your spouse and your spouse is eligible for coverage through his/her employment but chose not to take it. The spousal surcharge can be removed in certain circumstances by completing the spousal surcharge affidavit and attaching the required documents. Details can be found on the Department of Community Health Web site, www.dch.georgia.gov/shbp_plans.

Tobacco Surcharge:

A tobacco surcharge will be added to your monthly premium if you or any of your covered dependents have used tobacco products in the previous twelve months. The tobacco surcharge may be removed by completing the tobacco cessation requirements. Details can be found on the Department of Community Health Website, www.dch.georgia.gov/shbp_plans.

When to Enroll and When Coverage Begins

Initial Enrollment Period The Initial Enrollment Period is the first period of time when Eligible Persons can enroll.	Eligible Persons may enroll themselves and their Dependents.	Enrollment must be completed within 31 days of your date of hire.
Open Enrollment Period	Open Enrollment occurs every fall for the following plan year. Eligible Persons may enroll themselves and their Dependents. Any dependent(s) removed during the Open Enrollment period are not eligible for COBRA.	The SHBP determines the Open Enrollment Period. Coverage begins on January 1st of the following Plan year.
If you are:	**You can enroll:**	**Your coverage takes effect:**
▪ A current employee	▪ Or make coverage changes during Open Enrollment ▪ Or make coverage changes within 31 days of a qualifying event or upon loss of all eligible dependents if request is made within 31 days	▪ The upcoming January 1st. ▪ First of the month following request
▪ A newly hired employee	▪ Within 31 days of your hire date	▪ First of the month after a full calendar month of employment

Enrolling A Newly Eligible Dependent

If you have a new dependent due to marriage, birth, adoption, or full-time student enrollment you may enroll your dependent if you request coverage within 31 days of the qualifying event. Please contact your personnel/payroll office for instructions**. Do not wait for verification documentation to enroll your dependent(s).**

This next chart describes what you need to do if you wish to add a newly eligible dependent.

	To enroll a newly eligible dependent and…	**You will need to…**
Newly Eligible Dependent	… if your dependent is currently eligible for the tier you are enrolled in	… add within 31 days of the birth*, marriage, or adoption*.
	… if your current tier does not cover dependents	… change tiers within 31 days of the qualifying event, pay appropriate premium, and add dependent. Coverage starts on the first day of the month following the request.
	… if you have a court order, requiring you to enroll dependent child(ren)	… enroll in coverage. enroll the eligible child(ren). Coverage starts on the first day of the month following the request. You must change tier and pay appropriate premium if current tier does not include dependent(s).
	**To make coverage retroactive to the child's birth or placement, you must make the appropriate coverage premium payment(s) for coverage for the month of the birth or adoption contract and placement.*	

Identification Cards

After you enroll, you will receive a separate identification (ID) card for yourself and each covered dependent. The ID card must be presented when care is received.

If you do not receive your ID card within two weeks of enrollment, please contact CIGNA Healthcare Insurance Company Customer Service at 800-633-8519 (Active) or 800-942-6724 (Retiree).

When Coverage Begins For You

When your coverage starts depends on when you enroll and when you make requests that affect your coverage.

If you enroll:	Your coverage begins:
During an Open Enrollment period	On January 1st of the new Plan year
As a new employee	On the first day of the month following one full calendar month of employment
When you are reinstated or return to work from an unpaid leave of absence that occurred during the Open Enrollment period	On the first day of the month following the return or, if a judicial reinstatement, on the day specified in the settlement agreement
When you have a qualifying event	On the first day of the month following the request

Transferring Employees

If you are transferring between participating employers:

- Contact your new employer to coordinate continuous coverage.
- You must continue the same coverage, unless you have a qualifying event that allows a change in coverage.

There is no coverage lapse when your employment break is less than one calendar month and your new employer deducts the premium from your first paycheck.

Pre-Existing Conditions and Coverage Limits

A Pre-existing Condition (PEC) is any sickness, injury or other condition (except as noted below) from which medical advise, diagnosis, care or treatment, including prescription medication, was recommended or received within six months immediately preceding a Member's coverage effective date under the Plan.

New SHBP Members who enroll in the PPO and have a PEC have a 12-month coverage limitation period for their Pre-Existing Condition(s). Coverage for each PEC is limited to $1,000 during the first 12 months of Plan coverage.

For new employees, the 12-month coverage limitation period begins the first day of the month in which the new employee was hired.

The PEC limitation period does not apply to coverage for pregnancy, for a newborn, or for a newly adopted child or a child placed for adoption under the age of 18, if the child becomes covered within 31 days of birth or adoption.

Enrollees are treated as new Members, subject to the PEC limitation period, if they are enrolling in the PPO after a coverage break of four or more months.

Creditable Coverage

SHBP Members and dependents can reduce or eliminate the 12-month PEC limitation period by documenting "creditable coverage." Creditable coverage generally includes the health coverage you or a family member had immediately before joining the SHBP. Coverage under most group health plans, individual health policies and some governmental health programs qualifies as creditable coverage.

To reduce or eliminate the PEC limitation period for your own coverage:

- You must provide the SHBP with a Plan approved certificate of creditable coverage from one or more former health plans or insurers that states when your prior coverage started and ended.
- Any period of prior coverage under a qualifying plan will offset the 12-month PEC limitation period if the time between losing coverage and your first day of SHBP employment or qualifying event does not exceed 63 days.

If you are enrolling as a new hire, the 63-day period is measured from your last day of prior coverage up to your hire date. To reduce or eliminate the PEC limitation period for your dependents (including your spouse):

- For each dependent you want to cover you must provide the SHBP with a Plan approved certificate of creditable coverage stating why coverage ended, when prior coverage started and ended.
- Any period of prior coverage for that dependent under a qualifying plan will offset the 12-month PEC limitation period if no more than 63 days have elapsed between the dependent's loss of prior coverage and the first day of coverage under the SHBP (or your hire date, if you are enrolling as a new hire).

If you or a dependent (including spouse) had any break in former coverage lasting more than 63 days, you or your dependent will receive creditable coverage only for the period of time after the break ended.

Obtaining a Certificate of Creditable Coverage

Within two years after your former coverage terminates, you have the right to obtain a certificate of creditable coverage from your former health plan(s) to offset the PEC limitation period under the SHBP.

Please send your certificate of creditable coverage to the Plan. If you require assistance in obtaining a certificate of creditable coverage from a former employer, contact your current personnel/payroll office.

When Coverage Begins For Your Dependents

As a new employee, dependent coverage begins when your coverage begins. If you add dependents within 31 days of a qualifying event, coverage takes effect as described in the chart below. You must provide the following documentation before claims will be paid.

	If you add this dependent…	Coverage takes effect:
* Within 31 days prior to or after the Qualifying event	**A baby** Copy of certified birth certificate or a certification letter of birth required	On the first day of the month following the request; or On the day your child was born, if the proper premium is paid for the birth month; **Note: Do not hold request waiting for documentation. If documentation is received after 31 days the plan will retroactively cover the dependent back to the beginning of the current plan year or date of qualifying event, whichever is later, as long as premiums are paid.**
* Within 31 days prior to or after the Qualifying event	**An adopted child** Copy of certified adoption certificate required	*When you already have coverage that includes children:* • On the date of legal placement and physical custody *When you do not have a tier that covers dependent children* • On the date of legal placement and physical custody, if the correct tier premium is paid for the date of placement and custody • Request a tier coverage change
* Within 31 days prior to or after the Qualifying event	**A new spouse** Copy of certified marriage certificate required . Due to new Centers for Medicare and Medicaid Services (CMS) regulations, the spouse's social security number is required.	• Change to a coverage tier to include spouse *When coverage begins:* ▪ On the first day of the month following the request
* Within 31 days prior to or after the Qualifying event	**Stepchild(ren)** Copy of certified birth certificate showing your spouse is the natural parent; and copy of certified marriage license showing the natural parent is your spouse; and notarized statement that dependent lives in your home at least 180 days per year	On the first day of the month following your change to the appropriate coverage tier

*Note: When you add a dependent, the Plan will request dependent verification documentation. You must submit the documentation requested by the Plan in order to cover the dependent. **If documentation is received after 31 days, the plan will retroactively cover the dependent back to the beginning of the current plan year or date of qualifying event, whichever is later, as long as the correct tier premium is paid.**

Qualifying Events that Allow Coverage Changes for Active Members

If you are an actively employed Member and have one of the following qualifying events during the year, you may be able to make a coverage change that is consistent with the qualifying event. If you are a retiree, refer to the retiree section for permitted coverage changes. The following chart shows qualifying events and the corresponding changes that active Members can make.

If you have one of these qualifying events:	Within 31 days of qualifying event, you may:
Marriage Certified copy of marriage certificate required. Due to new Centers for Medicare and Medicaid Services (CMS) regulations, the spouse's social security number is required.	• Change your coverage tier to include your spouse; or • Discontinue coverage. You must submit a letter from the other plan documenting that you and your covered dependents are enrolled in your spouse's plan
Birth, adoption or legal guardianship 1) Birth: Copy of certified birth or letter of certification of birth. 2) Adoption: Adoption certificate or court order placing child in home. 3) Legal guardianship: Copy of court's legal documentation showing your financial responsibility for the dependent; and copy of certified birth certificate; and for legal guardianship a notarized statement that dependent lives with you in your home on a permanent basis.	• Enroll in coverage; • Change your coverage tier; • Enroll your eligible dependents; or • Change to any available option.
Divorce Copy of divorce decree and loss-of-coverage documentation required	• Enroll in coverage, if losing coverage through your spouse; • Remove your spouse from coverage; • Remove your stepchildren from coverage; • Change your coverage tier; or • Enroll your eligible dependent(s).
You or your spouse loses coverage through other employment Letter from other employer documenting loss of coverage and reason for loss is required	• Enroll your eligible dependent(s); • Enroll in coverage; or • Change your coverage tier
You, your spouse, or enrolled dependent loses or discontinues health benefit coverage through other employment, Medicaid or Medicare Letter from other employer, Medicaid, or Medicare documenting date and reason for loss or discontinuation required	• Enroll your eligible dependent(s); • Enroll in coverage; or • Change your coverage tier *Note: Effective April 1, 2009, for Medicaid only, the 31 days changes to 60 days for listed actions.*

If you have one of these qualifying events:	Within 31 days of qualifying event, you may:
Your spouse or your only enrolled dependent's employment status changes, resulting in a gain of coverage under a qualified plan "Includes spouse's Open Enrollment election" if same open enrollment period. Letter from other employer documenting coverage enrollment required and everyone covered under the SHBP must be enrolled in the plan	• Change your coverage tier; or • Discontinue coverage.
Your spouse makes an Open Enrollment change under spouse's employer's plan, creating an overlap or break in coverage because spouse's coverage has a different plan year Letter from other plan documenting overlap or break in coverage is required	• Enroll in coverage; • Enroll your eligible dependents(s); • Change your coverage tier; or • Discontinue coverage. You must document your spouse's plan covers all dependents.
Your former spouse loses coverage or plan is cancelled, resulting in loss of your dependent child(ren) coverage Letter from other plan documenting name, date, reason, and when coverage was lost.	• Enroll your eligible dependent(s); • Enroll in coverage; or • Change your coverage tier.
You or spouse acquire new coverage under spouse's employer's plan Letter from other plan documenting your effective date of coverage and names of covered dependents	• Change to employee only coverage; or • Discontinue coverage. You must document your spouse's plan covers all dependents.
You or your spouse is activated into military services Copy of orders required	• Enroll in coverage; • Change your coverage tier; or • Discontinue coverage.
You, your spouse, or all enrolled dependents become eligible for Medicare or Medicaid Required to submit proof of enrollment in Part A, B, and D. If you are actively working, enrollment in Medicare will not reduce your premiums. SHBP will remain primary as long as you are actively working unless you drop your SHBP coverage.	• Discontinue your coverage. Note, if you do not have SHBP coverage at the time you retire, you cannot have coverage as a retiree and will not be able to enroll for SHBP coverage

Loss of all covered dependents may be through divorce, death, legal separation, an only covered dependents exceeding the maximum age of eligibility, an only covered dependent no longer meeting full-time student requirements, marriage of an only covered dependent child, or a Qualified Medical Child Support Order (QMCSO) requiring a former spouse to provide health coverage for all covered natural children. You must notify SHBP within 31 days of qualifying event to change your coverage tier. Your next opportunity to change coverage tier would be during Open Enrollment.

Qualified Medical Child Support Orders

If a QMCSO requires:	You can:
You to provide coverage for your natural child(ren)	• Enroll or change coverage tier – there is no time limit for this change; documentation of the court order and the other coverage is required
Your former spouse to provide coverage for each of your enrolled natural child(ren)	• Change coverage tier – within 31 days of the court-ordered date; documentation of the court order and the coverage is required

Generally, a change in coverage takes effect the first of the month following receipt of the change request.

Important Note on Coverage Changes:

If your current Plan option is not offered in the upcoming Plan year and you do not elect a different option available to you during Open Enrollment or the Retiree Option Change Period, your coverage will be transferred automatically to an option selected by SHBP, with any applicable surcharges, effective January 1st of the subsequent plan year.

Open Access Plus Medical Benefits

Inpatient Certification Requirements - Out-of-Network

For You and Your Dependents

Pre-Admission Certification/Continued Stay Review for Hospital Confinement

Pre-Admission Certification (PAC) and Continued Stay Review (CSR) refer to the process used to certify the Medical Necessity and length of a Hospital Confinement when you or your Dependent require treatment in a Hospital:

- as a registered bed patient;
- for a Partial Hospitalization for the treatment of Mental Health or Substance Abuse.

You or your Dependent should request PAC prior to any non-emergency treatment in a Hospital described above for any out-of-network services. Your provider is responsible for obtaining PAC for in-network services. In the case of an emergency admission, you should contact the Review Organization within 24 hours after the admission. For an admission due to pregnancy, you should call the Review Organization by the end of the third month of pregnancy. CSR should be requested, prior to the end of the certified length of stay, for continued Hospital Confinement.

Covered Expenses incurred will be reduced by 50% for Hospital charges made for each separate admission to the Hospital:

- **unless PAC is received: (a) prior to the date of admission; or (b) in the case of an emergency admission, within 24 hours after the date of admission.**

Covered Expenses incurred for which benefits would otherwise be payable under this plan for the charges listed below will not include:

- **Hospital charges for Bed and Board, for treatment listed above for which PAC was performed, which are made for any day in excess of the number of days certified through PAC or CSR; and**
- **any Hospital charges for treatment listed above for which PAC was requested, but which was not certified as Medically Necessary.**

GM6000 PAC1 V33

PAC and CSR are performed through a utilization review program by a Review Organization with which CG has contracted.

In any case, those expenses incurred for which payment is excluded by the terms set forth above will not be considered as expenses incurred for the purpose of any other part of this plan, except for the "Coordination of Benefits" section. Please contact CIGNA Healthcare at 1-800-633-8519 (Actives) and select the option for pre-admission certification information.

Note: Obtaining pre-certification for an inpatient admission does not guarantee coverage. Be sure to review your plan guidelines carefully.

GM6000 PAC2 V9C

Outpatient Certification Requirements Out-of-Network

Outpatient Certification refers to the process used to certify the Medical Necessity of outpatient diagnostic testing and outpatient procedures, including, but not limited to, those listed in this section when performed as an outpatient in a Free-standing Surgical Facility, Other Health Care Facility or a Physician's office. You or your Dependent should call the toll-free number on the back of your I.D. card to determine if Outpatient Certification is required prior to any outpatient diagnostic testing or procedures. Outpatient Certification is performed through a utilization review program by a Review Organization with which CG has contracted. Outpatient Certification should only be requested for nonemergency procedures or services, and should be requested by you or your Dependent at least four working days (Monday through Friday) prior to having the procedure performed or the service rendered.

Covered Expenses incurred will be reduced by 50% for charges made for any outpatient diagnostic testing or procedure performed unless Outpatient Certification is received prior to the date the testing or procedure is performed.

Covered Expenses incurred will not include expenses incurred for charges made for outpatient diagnostic testing or procedures for which Outpatient Certification was performed, but, which was not certified as Medically Necessary.

In any case, those expenses incurred for which payment is excluded by the terms set forth above will not be considered as expenses incurred for the purpose of any other part of this plan, except for the "Coordination of Benefits" section.

Diagnostic Testing and Outpatient Procedures

Including, but not limited to:

Advanced radiological imaging – CT Scans, MRI, MRA or PET scans.

Hysterectomy

GM6000 SC1 PAC4 OCR8V5

Prior Authorization/Pre-Authorized

The term Prior Authorization means the approval that a Provider must receive from the Review Organization, prior to services being rendered, in order for certain services and benefits to be covered under this policy. Penalties will apply when items are not pre-authorized. Please see penalties outlined on the previous page.

- inpatient Hospital services;
- inpatient services at any participating Other Health Care Facility;
- outpatient facility services;
- intensive outpatient programs;
- advanced radiological imaging;
- nonemergency ambulance; or
- transplant services.
- durable medical equipment in excess of $250.

GM6000 05BPT16 V6

OPEN ACCESS PLUS MEDICAL BENEFITS

The Schedule

For You and Your Dependents

Open Access Plus Medical Benefits provide coverage for care In-Network and Out-of-Network. To receive Open Access Plus Medical Benefits, you and your Dependents may be required to pay a portion of the Covered Expenses for services and supplies. That portion is the Copayment, Deductible or Coinsurance.

Coinsurance

The term Coinsurance means the percentage of charges for Covered Expenses that an insured person is required to pay under the plan.

Copayments/Deductibles

Copayments are expenses to be paid by you or your Dependent for covered services. Deductibles are also expenses to be paid by you or your Dependent. Deductible amounts are separate from and not reduced by Copayments. Copayments and Deductibles are in addition to any Coinsurance. Once the Deductible maximum in The Schedule has been reached during the calendar year, you and your family need not satisfy any further medical deductible for the remainder of that calendar year.

Out-of-Pocket Expenses

Out-of-Pocket Expenses are Covered Expenses incurred for In-Network and Out-of-Network charges that are not paid by the benefit plan because of any:

- Coinsurance.
- Plan Deductibles.
- inpatient hospital facility copayments or deductibles.

Charges will not accumulate toward the Out-of-Pocket Maximum for Covered Expenses incurred for:

- copayments (other than inpatient hospital facility copayments).
- non-compliance penalties.
- provider charges in excess of the Maximum Reimbursable Charge.

When the Out-of-Pocket Maximum shown in The Schedule is reached, Injury and Sickness benefits are payable at 100% except for:

- non-compliance penalties.
- provider charges in excess of the Maximum Reimbursable Charge.

Accumulation of Plan Deductibles and Out-of-Pocket Maximums

All in-network services accumulate only towards in-network deductibles and out-of-pocket maximums. All out-of-network services accumulate only towards out-of-network deductibles and out-of-pocket maximums. All other plan maximums and service-specific maximums (dollar and occurrence) cross-accumulate between In- and Out-of-Network unless otherwise noted.

Multiple Surgical Reduction

Multiple surgeries performed during one operating session result in payment reduction of 50% to the surgery of lesser charge. The most expensive procedure is paid as any other surgery.

OPEN ACCESS PLUS MEDICAL BENEFITS

The Schedule

Assistant Surgeon and Co-Surgeon Charges

Assistant Surgeon

The maximum amount payable will be limited to charges made by an assistant surgeon that do not exceed 20 percent of the surgeon's allowable charge. (For purposes of this limitation, allowable charge means the amount payable to the surgeon prior to any reductions due to coinsurance or deductible amounts.)

Co-Surgeon

The maximum amount payable will be limited to charges made by co-surgeons that do not exceed 20 percent of the surgeon's allowable charge plus 20 percent. (For purposes of this limitation, allowable charge means the amount payable to the surgeons prior to any reductions due to coinsurance or deductible amounts.)

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Lifetime Maximum	$2,000,000	
Coinsurance Levels	90% of Covered Expenses	60% of the Maximum Reimbursable Eligible Charge after plan deductible
Individual Deductible Calculation: Family members meet only their individual deductible and then their claims will be covered under the plan coinsurance; if the family deductible has been met prior to their individual deductible being met, their claims will be paid at the plan coinsurance.		
Calendar Year Deductible for Active Employees		
Employee	$500	$1,000
Employee + Spouse	$1,000	$2,000
Employee + Child(ren)	$1,000	$2,000
Employee + Spouse + Child(ren)	$1,500	$3,000
Calendar Year Deductible for Retirees		
Employee	$500	$1,000
Employee + Family	$1,500	$3,000
Individual Out-of-Pocket Calculation: Family members meet only their individual Out-of-Pocket and then their claims will be covered at 100% of eligible charges; if the family Out-of-Pocket has been met prior to their individual Out-of-Pocket being met, their claims will be paid at 100% of eligible charges.		
Out-of-Pocket Maximum for Active Employees		
Employee	$1,500	$3,000
Employee + Spouse	$2,250	$4,500
Employee + Child(ren)	$2,250	$4,500
Employee + Spouse + Child(ren)	$3,000	$6,000
Out-of-Pocket Maximum for Retirees		
Employee	$1,500	$3,000
Employee + Family	$3,000	$6,000

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Out-of-Pocket Expenses Out-of-Pocket Expenses are Covered Expenses incurred for In-Network and Out-of-Network charges that are not paid by the benefit plan because of any: • Coinsurance. • Plan Deductibles. • inpatient hospital facility copayments or deductibles. Charges will not accumulate toward the Out-of-Pocket Maximum for Covered Expenses incurred for: • copayments (other than inpatient hospital facility copayments). • non-compliance penalties. • provider charges in excess of the Maximum Reimbursable Charge. When the Out-of-Pocket Maximum shown in The Schedule is reached, Injury and Sickness benefits are payable at 100% except for: • non-compliance penalties. • provider charges in excess of the Maximum Reimbursable Charge. ***Note: Charges from nonparticipating providers are subject to balance billing. In these situations, you may billed for the amount that exceeds the maximum reimbursable eligible charge. These charges are the member's responsibility and do not count toward deductibles or out-of-pocket spending limits.*** ***The SHBP does not have the legal authority to intervene when non-Contracted providers balance bill you. As a result, the SHBP cannot reduce or eliminate amounts balance billed. The SHBP cannot make additional payments above the allowed amounts when you are balance billed by non-Contracted providers.***		
Physician's Services		
Primary Care Physician's Office visit	$30 per office visit copay, then 100% coverage	60% of the Maximum Reimbursable Eligible Charge after plan deductible
Specialty Care Physician's Office Visits, Consultant and Referral Physician's Services	$30 per office visit copay, then 100% coverage	60% of the Maximum Reimbursable Eligible Charge after plan deductible
Surgery Performed In the Physician's Office	$30 per office visit copay, then 100% coverage	60% of the Maximum Reimbursable Eligible Charge after plan deductible
Second Opinion Consultations (provided on a voluntary basis)	$30 per office visit copay, then 100% coverage	60% of the Maximum Reimbursable Eligible Charge after plan deductible
Allergy Treatment/Injections	100% coverage	60% of the Maximum Reimbursable Eligible Charge after plan deductible
Allergy Serum (dispensed by the Physician in the office)	100% coverage	60% of the Maximum Reimbursable Eligible Charge after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Preventive Care		
Maximum: $1,000 per person per calendar		
Routine Physician's Office Visit *Note: Charges for lab and radiology services will be subject to the plan's Preventive Care dollar maximum.*	$30 per office visit copay, then 100% coverage up to the combined preventive care $1,000 per person per calendar year maximum	In-Network coverage only
Routine Immunizations (children to age 18)	100% coverage (not subject to $1,000 per person per calendar year preventive care maximum)	In-Network coverage only
Routine Immunizations (19 and over)	100% coverage up to the combined preventive care $1,000 per person per calendar year maximum	In-Network coverage only
Routine Mammogram	$30 per office visit copay, then 100% coverage up to the combined preventive care $1,000 per person per calendar year maximum	In-Network coverage only
Routine PSA, Pap Smear	100% coverage up to the combined preventive care $1,000 per person per calendar year maximum	In-Network coverage only
Routine Colonoscopy Screenings	100% coverage (not subject to $1,000 per person per calendar year preventive care maximum)	In-Network coverage only
Inpatient Hospital - Facility Services	$250 per admission, then 90% of Covered Expenses after plan deductible	$250 per admission, then 60% of the Maximum Reimbursable Eligible Charge after plan deductible **** Pre-authorization required***
Semi-Private Room and Board	Limited to the semi-private room negotiated rate	Limited to the semi-private room rate
Private Room	Limited to the semi-private room negotiated rate	Limited to the semi-private room rate
Special Care Units (ICU/CCU)	Limited to the negotiated rate	Limited to the ICU/CCU daily room rate
Outpatient Facility Services Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room	90% of Covered Expenses after plan deductible	60% of the Maximum Reimbursable Eligible Charge after plan deductible **** Pre-authorization may be required***

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Well Newborn Inpatient Facility Services and Other Related Charges	100% coverage	60% of the Maximum Reimbursable Eligible Charge after plan deductible
Inpatient Hospital Physician's Visits/Consultations	90% of Covered Expenses after plan deductible	60% of the Maximum Reimbursable Eligible Charge after plan deductible
Inpatient Hospital Professional Services Surgeon Radiologist Pathologist Anesthesiologist	90% of Covered Expenses after plan deductible	60% of the Maximum Reimbursable Eligible Charge after plan deductible
Outpatient Professional Services Surgeon Radiologist Pathologist Anesthesiologist	90% of Covered Expenses after plan deductible	60% of the Maximum Reimbursable Eligible Charge after plan deductible
Emergency and Urgent Care Services		
Physician's Office Visit	$30 per office visit copay, then 100% coverage	$30 per office visit copay, then 100% coverage (except if not a true emergency, then 60% of the Maximum Reimbursable Eligible Charge after plan deductible)
Hospital Emergency Room	$100 per visit copay, * then 90% of Covered Expenses after plan deductible *waived if admitted	$100 per visit copay,* then 90% of Covered Expenses after plan deductible (except if not a true emergency, then 60% of the Maximum Reimbursable Eligible Charge after plan deductible) *waived if admitted

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Emergency and Urgent Care Services		
Outpatient Professional services (radiology, pathology and ER Physician)	90% of Covered Expenses after plan deductible	90% of Covered Expenses after plan deductible (except if not a true emergency, then 60% of the Maximum Reimbursable Eligible Charge after plan deductible)
Urgent Care Facility or Outpatient Facility	$45 per visit copay,* then 90% of Covered Expenses after plan deductible	$45 per visit copay,* then 90% of Covered Expenses after plan deductible (except if not a true emergency, then 60% of the Maximum Reimbursable Eligible Charge after plan deductible)
	*waived if admitted	*waived if admitted
X-ray and/or Lab performed at the Emergency Room/Urgent Care Facility (billed by the facility as part of the ER/UC visit)	90% of Covered Expenses after plan deductible	90% of Covered Expenses after plan deductible (except if not a true emergency, then 60% of the Maximum Reimbursable Eligible Charge after plan deductible)
Independent x-ray and/or Lab Facility in conjunction with an ER visit	90% of Covered Expenses after plan deductible	90% of Covered Expenses after plan deductible (except if not a true emergency, then 60% of the Maximum Reimbursable Eligible Charge after plan deductible)
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.)	90% of Covered Expenses after plan deductible	90% of Covered Expenses after plan deductible (except if not a true emergency, then 60% of the Maximum Reimbursable Eligible Charge after plan deductible)
Ambulance (non-emergency transportation, ground or air, is excluded, unless approved by CIGNA)	90% of Covered Expenses after plan deductible	90% of Covered Expenses after plan deductible (except if not a true emergency, then 60% of the Maximum Reimbursable Eligible Charge after plan deductible)
Skilled Nursing Facilities (including Sub-Acute Facilities) Calendar Year Maximum: 120 days	$250 per admission copay, then 90% of Covered Expenses after plan deductible. Copay waived if transferred directly from acute facility.	Covered In-network Only
Rehabilitation Hospitals (including Inpatient Long Term Acute Care) Calendar Year Maximum: Unlimited	$250 per admission copay, then 90% of Covered Expenses after plan deductible. Copay waived if transferred directly from acute facility.	$250 per admission copay, then 60% of the Maximum Reimbursable Eligible Charge after plan deductible. Copay waived if transferred directly from acute facility. **** Pre-authorization required***

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Laboratory and Radiology Services (including pre-admission testing)		
Physician's Office Visit	90% of Covered Expenses after deductible if only x-ray and/or lab services performed and billed.	60% of the Maximum Reimbursable Eligible Charge after plan deductible
Outpatient Hospital Facility	90% of Covered Expenses after plan deductible	60% of the Maximum Reimbursable Eligible Charge after plan deductible
Independent X-ray and/or Lab Facility *Note: Lab and x-ray services coded as preventive care will be applied to the preventive care maximum.*	90% of Covered Expenses after plan deductible	60% of the Maximum Reimbursable Eligible Charge after plan deductible
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans and PET Scans)		**** Pre-authorization required***
Inpatient Facility	90% of Covered Expenses after plan deductible	60% of the Maximum Reimbursable Eligible Charge after plan deductible
Outpatient Facility	90% of Covered Expenses after plan deductible	60% of the Maximum Reimbursable Eligible Charge after plan deductible
Physician's Office Visit	90% of Covered Expenses after plan deductible	60% of the Maximum Reimbursable Eligible Charge after plan deductible
Outpatient Short-Term Rehabilitative Therapy Calendar Year Maximum: 40 days per therapy Includes: • Cardiac Rehab • Physical Therapy • Speech Therapy • Occupational Therapy • Pulmonary Rehab • Cognitive Therapy *Note: 40 days equals 40 visits per therapy. Treatment is limited to one visit per day.*	$20 per visit copay, then 90% of Covered Expenses after plan deductible *Note: Outpatient Short Term Rehab copay applies, regardless of place of service, including the home.*	60% of the Maximum Reimbursable Eligible Charge after plan deductible **** Pre-authorization required***

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Chiropractic Care Calendar Year Maximum: 20 days Physician's Office Visit	$30 per office visit copay, then 90% of Covered Expenses, no deductible	60% of the Maximum Reimbursable Eligible Charge after plan deductible
Home Health Care Calendar Year Maximum: Unlimited, when prior approved by CIGNA (includes outpatient private nursing when approved as medically necessary)	90% of Covered Expenses after plan deductible	60% of the Maximum Reimbursable Eligible Charge after plan deductible **** Pre-authorization required***
Hospice Inpatient Services	100% of Covered Expenses after plan deductible	60% of the Maximum Reimbursable Eligible Charge after plan deductible
Outpatient Services	100% of Covered Expenses after plan deductible	60% of the Maximum Reimbursable Eligible Charge after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Maternity Care Services		
Initial Visit to Confirm Pregnancy	$30 per office visit copay, then 100% coverage	60% of the Maximum Reimbursable Eligible Charge after plan deductible
All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)	90% of Covered Expenses, no deductible	60% of the Maximum Reimbursable Eligible Charge after plan deductible
Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist	$30 per office visit copay, then 100% coverage	60% of the Maximum Reimbursable Eligible Charge after plan deductible
Delivery – Facility (Inpatient Hospital, Birthing Center)	$250 per admission, then 90% of Covered Expenses after plan deductible	$250 per admission, then 60% of the Maximum Reimbursable Eligible Charge after plan deductible
Abortion Includes elective and non-elective procedures		
Physician's Office Visit	$30 per office visit copay, then 100% coverage	60% of the Maximum Reimbursable Eligible Charge after plan deductible
Inpatient Facility	$250 per admission, then 90% of Covered Expenses after plan deductible	$250 per admission, then 60% of the Maximum Reimbursable Eligible Charge after plan deductible **** Pre-authorization required***
Outpatient Facility	90% of Covered Expenses after plan deductible	60% of the Maximum Reimbursable Eligible Charge after plan deductible **** Pre-authorization required***
Physician's Services	90% of Covered Expenses after plan deductible	60% of the Maximum Reimbursable Eligible Charge after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Family Planning Services		
Office Visits, Lab and Radiology Tests and Counseling *Note: Includes coverage for contraceptives and contraceptive devices (e.g. Depo-Provera and Intrauterine Devices (IUDs). Diaphragms will also be covered when services are provided in the physician's office.*	$30 per office visit copay, then 100% coverage	60% of the Maximum Reimbursable Eligible Charge after plan deductible
Surgical Sterilization Procedures for Vasectomy/Tubal Ligation (excludes reversals)		
Physician's Office Visit	$30 per office visit copay, then 100% coverage	60% of the Maximum Reimbursable Eligible Charge after plan deductible
Inpatient Facility	$250 per admission, then 90% of Covered Expenses after plan deductible	$250 per admission, then 60% of the Maximum Reimbursable Eligible Charge after plan deductible **** Pre-authorization required***
Outpatient Facility	90% of Covered Expenses after plan deductible	60% of the Maximum Reimbursable Eligible Charge after plan deductible **** Pre-authorization required***
Physician's Services	90% of Covered Expenses after plan deductible	60% of the Maximum Reimbursable Eligible Charge after plan deductible
Infertility Treatment Services Not Covered include: • Testing performed specifically to determine the cause of infertility. • Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition). • Artificial means of becoming pregnant (e.g. Artificial Insemination, In-vitro, GIFT, ZIFT, etc).	*Note: Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.*	*Note: Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.*

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Organ Transplants Includes all medically appropriate, non-experimental transplants	*Note: Cornea transplants are not covered at CIGNA Lifesource Facilities. These services will be covered at the CIGNA Participating Provider benefit level.*	
Physician's Office Visit	$30 per office visit copay, then 100% coverage	In-Network coverage only
Inpatient Facility		
CIGNA Lifesource Transplant Network Facility	$250 per admission copay, then 100% coverage	In-Network coverage only
Non-Lifesource, CIGNA Contracted Facility	90% of Covered Expenses after $250 per admission copay and plan deductible	In-Network coverage only
Physician's Services		
CIGNA Lifesource Transplant Network Provider	100% coverage	In-Network coverage only
Non-Lifesource, CIGNA Contracted Provider	90% of Covered Expenses after plan deductible	In-Network coverage only
Lifetime Travel Maximum: $10,000 per transplant	100% coverage (only available when using Lifesource facility)	In-Network coverage only
Durable Medical Equipment Calendar Year Maximum: Unlimited	90% of Covered Expenses after plan deductible ***Note: Items over $250 may require pre-authorization.***	60% of the Maximum Reimbursable Eligible Charge after plan deductible ***Note: Items over $250 may require pre-authorization.***
External Prosthetic Appliances Calendar Year Maximum: $50,000	90% of Covered Expenses after plan deductible	60% of the Maximum Reimbursable Eligible Charge after plan deductible **** Pre-authorization required***
Wigs Limited to charges for hair loss related to cancer/chemotherapy treatment Maximum: $750 per lifetime	100% of Covered Expenses after plan deductible	100% of Covered Expenses after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Nutritional Evaluation and Counseling		
Physician's Office Visit	$30 per office visit copay, then 100% coverage	$30 per office visit copay, then 100% coverage
Outpatient Facility	90% of Covered Expenses after plan deductible	90% of Covered Expenses after plan deductible
Physician's Services	90% of Covered Expenses after plan deductible	90% of Covered Expenses after plan deductible
Calendar Year Maximum: 3 visits		
Accidental Dental Limited to charges made for a continuous course of dental treatment started within six months of an injury to sound, natural teeth.		
Physician's Office Visit	$30 per office visit copay, then 100% coverage	60% of the Maximum Reimbursable Eligible Charge after plan deductible
Inpatient Facility	$250 per admission, then 90% of Covered Expenses after plan deductible	$250 per admission, then 60% of the Maximum Reimbursable Eligible Charge after plan deductible **** Pre-authorization required***
Outpatient Facility	90% of Covered Expenses after plan deductible	60% of the Maximum Reimbursable Eligible Charge after plan deductible **** Pre-authorization required***
Physician's Services	90% of Covered Expenses after plan deductible	60% of the Maximum Reimbursable Eligible Charge after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
TMJ Surgical and Non-Surgical Subject to medical necessity.		
Physician's Office Visit	$30 per office visit copay, then 100% coverage	60% of the Maximum Reimbursable Eligible Charge after plan deductible
Inpatient Facility	$250 per admission, then 90% of Covered Expenses after plan deductible	$250 per admission, then 60% of the Maximum Reimbursable Eligible Charge after plan deductible **** Pre-authorization required***
Outpatient Facility	90% of Covered Expenses after plan deductible	60% of the Maximum Reimbursable Eligible Charge after plan deductible **** Pre-authorization required***
Physician's Services *Note: Coverage for diagnostic testing and non-surgical treatment up to $1,100 per person per lifetime maximum benefit. Coverage for Occlusal Orthotic (splints) appliances: $500 per person per lifetime maximum benefit.*	90% of Covered Expenses after plan deductible	60% of the Maximum Reimbursable Eligible Charge after plan deductible
Routine Foot Disorders	Not covered except for services associated with foot care for diabetes and peripheral vascular disease.	Not covered except for services associated with foot care for diabetes and peripheral vascular disease.

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Treatment Resulting From Life Threatening Emergencies Related to Mental Health or Substance Abuse Conditions Medical treatment required as a result of an emergency, such as a suicide attempt, will be considered a medical expense until the medical condition is stabilized and will not count toward any plan limits that are shown in the Schedule for mental health and substance abuse services including in-hospital services. Once the medical condition is stabilized, whether the treatment will be characterized as either a medical expense or a mental health/substance abuse expense will be determined by the utilization review Physician in accordance with the applicable mixed services claim guidelines.		
Mental Health **(All Services require pre-authorization)**		
Inpatient	$250 per admission, then 90% of Covered Expenses after plan deductible	$250 per admission, then 60% of the Maximum Reimbursable Eligible Charge after plan deductible
Outpatient	$30 per office visit copay, then 100% coverage	60% of the Maximum Reimbursable Eligible Charge after plan deductible
Outpatient Group Therapy (One group therapy session equals one individual therapy session)	$10 per office visit copay, then 100% coverage	60% of the Maximum Reimbursable Eligible Charge after plan deductible
Intensive Outpatient	90% of Covered Expenses after plan deductible	60% of the Maximum Reimbursable Eligible Charge after plan deductible
Substance Abuse **(All Services require pre-authorization)**		
Inpatient Acute detox: requires 24 hour nursing; Acute Inpatient Rehab: requires 24 hour nursing	$250 per admission, then 90% of Covered Expenses after plan deductible	$250 per admission, then 60% of the Maximum Reimbursable Eligible Charge after plan deductible
Outpatient	$30 per office visit copay, then 100% coverage	60% of the Maximum Reimbursable Eligible Charge after plan deductible
Intensive Outpatient	90% of Covered Expenses after plan deductible	60% of the Maximum Reimbursable Eligible Charge after plan deductible

Covered Expenses

The term Covered Expenses means the expenses incurred by or on behalf of a person for the charges listed below if they are incurred after becoming insured for these benefits. Expenses incurred for such charges are considered Covered Expenses to the extent that the services or supplies provided are recommended by a Physician, and are Medically Necessary for the care and treatment of an Injury or a Sickness, as determined by CG. **Any applicable Copayments, Deductibles or limits are shown in The Schedule.**

Covered Expenses

- Charges made by a Hospital, on its own behalf, for Bed and Board and other Necessary Services and Supplies; except that for any day of Hospital Confinement, Covered Expenses will not include that portion of charges for Bed and Board which is more than the Bed and Board Limit shown in The Schedule.
- Charges for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided.
- Charges made by a Hospital, on its own behalf, for medical care and treatment received as an outpatient.
- Charges made by a Free-Standing Surgical Facility, on its own behalf for medical care and treatment.
- Charges made on its own behalf, by an Other Health Care Facility, including a Skilled Nursing Facility, a Rehabilitation Hospital or a subacute facility for medical care and treatment; except that for any day of Other Health Care Facility confinement, Covered Expenses will not include that portion of charges which are in excess of the Other Health Care Facility Daily Limit shown in The Schedule.
- Charges made for Emergency Services and Urgent Care.
- Charges made by a Physician or a Psychologist for professional services.
- Charges made by a Nurse, other than a member of your family or your Dependent's family, for professional nursing service.

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- Charges made for anesthetics and their administration; diagnostic x-ray and laboratory examinations; x-ray, radium, and radioactive isotope treatment; chemotherapy; blood transfusions; oxygen and other gases and their administration.

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- Charges made for a mammogram for women ages 35 to 69, every one to two years, or at any age for women at risk, when recommended by a Physician.
- Charges made for an annual Papanicolaou laboratory screening test.
- Charges for annual ovarian cancer surveillance tests for women age 35 and over at risk for ovarian cancer. Annual ovarian cancer surveillance tests are annual screenings using CA-125 serum tumor marker testing, transvaginal ultrasound, and pelvic examination. A woman at risk is defined as a woman testing positive for BRCA1 or BRCA2 mutations, or one having a family history with: (a) one or more first or second degree relatives with ovarian cancer; (b) clusters of women relatives with breast cancer; or (c) nonpolyposis colorectal cancer.
- Charges made for an annual prostate-specific antigen test (PSA).
- Charges made for colorectal cancer screening, examinations and laboratory tests according to the most recently published guidelines and recommendations established by the American Cancer Society, in consultation with the American College of Gastroenterology and the American College of Radiology, if deemed appropriate by the Physician in consultation with the insured.

- Charges for the treatment of children's cancer for Dependent children who are: (a) diagnosed with cancer prior to their 19th birthday; and (b) enrolled in an approved clinical trial program for the treatment of children's cancer. Approved clinical trial programs are prescription drug clinical trial programs in the state of Georgia, as approved by the Federal Food and Drug Administration or the National Cancer Institute that will:
  - introduce new therapies and regimens which are more cost effective, and test them against standard therapies and regimens.
  - be certified by and will utilize the standards for acceptable protocols established by the Pediatric Oncology Group, Children's Cancer Group, or the Commissioner of Insurance.

  Covered Expenses will not include charges provided at no cost by the provider, or charges for treatment under the trial program which would not standardly be covered by CG.
- Charges for appropriate counseling, medical services connected with surgical therapies, including vasectomy and tubal ligation.
- Charges made for laboratory services, radiation therapy and other diagnostic and therapeutic radiological procedures.
- Charges made for Family Planning, including medical history, physical exam, related laboratory tests, medical supervision in accordance with generally accepted medical practices, other medical services, information and counseling on contraception, implanted/injected contraceptives.
- Charges made for Routine Preventive Care including immunizations, not to exceed the maximum shown in the Schedule. Routine Preventive Care means health care assessments, wellness visits and any related services.

  In addition, Covered Expenses will include expenses incurred at any of the Approximate Age Intervals shown below for a Dependent child who is age 5 or less, for charges made for Child Wellness Services consisting of the following services delivered or supervised by a Physician, in keeping with prevailing medical standards:
  - a history;
  - physical examination;
  - development assessment;
  - anticipatory guidance; and
  - appropriate immunizations and laboratory tests;

  Excluding any charges for:
  - more than one visit to one provider for Child Wellness Services at each of the Approximate Age Intervals, up to a total of 12 visits for each Dependent child;
  - services for which benefits are otherwise provided under this Covered Expenses section;
  - services for which benefits are not payable according to the Expenses Not Covered section.

  It is provided that any Deductible that would otherwise apply will be waived for those Covered Expenses incurred for Child Wellness Services.

  Approximate Age Intervals are: Birth, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 2 years, 3 years, 4 years and 5 years.
- Charges for or in connection with the treatment of autism. Autism is defined as a developmental neurological disorder, usually appearing in the first three years of life, which affects normal brain functions and is manifested by compulsive, ritualistic behavior and severely impaired social interaction and communication skills.

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- Surgical or nonsurgical treatment of TMJ Dysfunction.

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- Orthognathic surgery to repair or correct a severe facial deformity or disfigurement that orthodontics alone can not correct, provided:
  - the deformity or disfigurement is accompanied by a documented clinically significant functional impairment, and there is a reasonable expectation that the procedure will result in meaningful functional improvement; or
  - the orthognathic surgery is Medically Necessary as a result of tumor, trauma, disease or;
  - the orthognathic surgery is performed prior to age 19 and is required as a result of severe congenital facial deformity or congenital condition.

  Repeat or subsequent orthognathic surgeries for the same condition are covered only when the previous orthognathic surgery met the above requirements, and there is a high probability of significant additional improvement as determined by the utilization review Physician.

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Clinical Trials

- Charges made for routine patient services associated with cancer clinical trials approved and sponsored by the federal government. In addition the following criteria must be met:
  - the cancer clinical trial is listed on the NIH web site www.clinicaltrials.gov as being sponsored by the federal government;
  - the trial investigates a treatment for terminal cancer and: (1) the person has failed standard therapies for the disease; (2) cannot tolerate standard therapies for the disease; or (3) no effective nonexperimental treatment for the disease exists;
  - the person meets all inclusion criteria for the clinical trial and is not treated “off-protocol”;
  - the trial is approved by the Institutional Review Board of the institution administering the treatment; and
  - coverage will not be extended to clinical trials conducted at nonparticipating facilities if a person is eligible to participate in a covered clinical trial from a Participating Provider.

  Routine patient services do not include, and reimbursement will not be provided for:
  - the investigational service or supply itself;
  - services or supplies listed herein as Exclusions;
  - services or supplies related to data collection for the clinical trial (i.e., protocol-induced costs);
  - services or supplies which, in the absence of private health care coverage, are provided by a clinical trial sponsor or other party (e.g., device, drug, item or service supplied by manufacturer and not yet FDA approved) without charge to the trial participant.

Genetic Testing

- Charges made for genetic testing that uses a proven testing method for the identification of genetically-linked inheritable disease. Genetic testing is covered only if:
  - a person has symptoms or signs of a genetically-linked inheritable disease;
  - it has been determined that a person is at risk for carrier status as supported by existing peer-reviewed, evidence-based, scientific literature for the development of a genetically-linked inheritable disease when the results will impact clinical outcome; or

GM6000 05BPT1

  - the therapeutic purpose is to identify specific genetic mutation that has been demonstrated in the existing peer-reviewed, evidence-based, scientific literature to directly impact treatment options.

  Pre-implantation genetic testing, genetic diagnosis prior to embryo transfer, is covered when either parent has an inherited disease or is a documented carrier of a genetically-linked inheritable disease.

Genetic counseling is covered if a person is undergoing approved genetic testing, or if a person has an inherited disease and is a potential candidate for genetic testing. Genetic counseling is limited to 3 visits per calendar year for both pre- and postgenetic testing.

Nutritional Evaluation and Counseling

- Charges made for nutritional evaluation and counseling when diet is a part of the medical management of a documented disease.

Internal Prosthetic/Medical Appliances

- Charges made for internal prosthetic/medical appliances that provide permanent or temporary internal functional supports for nonfunctional body parts are covered. Medically Necessary repair, maintenance or replacement of a covered appliance is also covered.

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Home Health Services

- Charges made for Home Health Services when you: (a) require skilled care; (b) are unable to obtain the required care as an ambulatory outpatient; and (c) do not require confinement in a Hospital or Other Health Care Facility.

  Home Health Services are provided only if CG has determined that the home is a medically appropriate setting. If you are a minor or an adult who is dependent upon others for nonskilled care and/or custodial services (e.g., bathing, eating, toileting), Home Health Services will be provided for you only during times when there is a family member or care giver present in the home to meet your nonskilled care and/or custodial services needs.

  Home Health Services are those skilled health care services that can be provided during visits by Other Health Care Professionals. The services of a home health aide are covered when rendered in direct support of skilled health care services provided by Other Health Care Professionals. A visit is defined as a period of 2 hours or less. Home Health Services are subject to a maximum of 16 hours in total per day. Necessary consumable medical supplies and home infusion therapy administered or used by Other Health Care Professionals in providing Home Health Services are covered. Home Health Services do not include services by a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house even if that person is an Other Health Care Professional. Skilled nursing services or private duty nursing services provided in the home are subject to the Home Health Services benefit terms, conditions and benefit limitations. Physical, occupational, and other Short-Term Rehabilitative Therapy services provided in the home are not subject to the Home Health Services benefit limitations or Short-term Rehabilitative Therapy Maximums shown in the Schedule.

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Hospice Care Services

- Charges made for a person who has been diagnosed as having six months or fewer to live, due to Terminal Illness, for the following Hospice Care Services provided under a Hospice Care Program:
  - by a Hospice Facility for Bed and Board;
  - by a Hospice Care program for Services and Supplies;
  - by a Hospice Facility for services provided on an outpatient basis;
  - by a Physician for professional services;
  - by a Psychologist, social worker, family counselor or ordained minister for individual and family bereavement counseling;
  - for pain relief treatment, including drugs, medicines and medical supplies;
  - by an Other Health Care Facility for:
    - part-time or intermittent nursing care by or under the supervision of a Nurse;

- part-time or intermittent services of an Other Health Care Professional;

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- physical, occupational and speech therapy;
- medical supplies; drugs and medicines lawfully dispensed only on the written prescription of a Physician; and laboratory services; but only to the extent such charges would have been payable under the policy if the person had remained or been Confined in a Hospital or Hospice Facility.

The following charges for Hospice Care Services are not included as Covered Expenses:

- for the services of a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house;
- for any period when you or your Dependent is not under the care of a Physician;
- for services or supplies not listed in the Hospice Care Program;
- for any curative or life-prolonging procedures;
- to the extent that any other benefits are payable for those expenses under the policy;
- for services or supplies that are primarily to aid you or your Dependent in daily living;

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Mental Health and Substance Abuse Services

Mental Health Services are services that are required to treat a disorder that impairs the behavior, emotional reaction or thought processes. In determining benefits payable, charges made for the treatment of any physiological conditions related to Mental Health will not be considered to be charges made for treatment of Mental Health.

Substance Abuse is defined as the psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care, and treatment. In determining benefits payable, charges made for the treatment of any physiological conditions related to rehabilitation services for alcohol or drug abuse or addiction will not be considered to be charges made for treatment of Substance Abuse

Inpatient Mental Health Services

Services that are provided by a Hospital while you or your Dependent is Confined in a Hospital for the treatment and evaluation of Mental Health. Inpatient Mental Health Services include Partial Hospitalization and Mental Health Residential Treatment Services.

Inpatient Mental Health services are exchangeable with **Partial Hospitalization** sessions when services are provided for not less than 4 hours and not more than 12 hours in any 24-hour period. The exchange for services will be two Partial Hospitalization sessions are equal to one day of inpatient care.

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Outpatient Mental Health Services

Services of Providers who are qualified to treat Mental Health when treatment is provided on an outpatient basis, while you or your Dependent is not Confined in a Hospital, and is provided in an individual, group or Mental Health Intensive Outpatient Therapy Program. Covered services include, but are not limited to, outpatient treatment of conditions such as: anxiety or depression which interfere with daily functioning; emotional adjustment or concerns related to chronic conditions, such as psychosis or depression; emotional reactions associated with marital problems or divorce; child/adolescent problems of conduct or poor impulse control; affective disorders; suicidal or homicidal threats or acts; eating disorders; or acute exacerbation of chronic Mental Health conditions (crisis intervention and relapse prevention) and outpatient testing and assessment.

A Mental Health Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Mental Health program. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling nine or more hours in a week. Mental Health Intensive Outpatient Therapy Program services are exchanged with Outpatient Mental Health services at a rate of one visit of Mental Health Intensive Outpatient Therapy being equal to one visit of Outpatient Mental Health Services.

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Inpatient Substance Abuse Rehabilitation Services

Services provided for rehabilitation, while you or your Dependent is Confined in a Hospital, when required for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs. Inpatient Substance Abuse Services include Partial Hospitalization sessions and Residential Treatment services.

Inpatient Substance Abuse services are exchangeable with **Partial Hospitalization** sessions when services are provided for not less than 4 hours and not more than 12 hours in any 24-hour period. The exchange for services will be two Partial Hospitalization sessions are equal to one day of inpatient care.

Outpatient Substance Abuse Rehabilitation Services

Services provided for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs, while you or your Dependent is not Confined in a Hospital, including outpatient rehabilitation in an individual, or a Substance Abuse Intensive Outpatient Therapy Program.

A Substance Abuse Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Substance Abuse program. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling nine, or more hours in a week. Substance Abuse Intensive Outpatient Therapy Program services are exchanged with Outpatient Substance Abuse services at a rate of one visit of Substance Abuse Intensive Outpatient Therapy being equal to one visit of Outpatient Substance Abuse Rehabilitation Services.

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Substance Abuse Detoxification Services

Detoxification and related medical ancillary services are provided when required for the diagnosis and treatment of addiction to alcohol and/or drugs. CG will decide, based on the Medical Necessity of each situation, whether such services will be provided in an inpatient or outpatient setting.

Mental Health and Substance Abuse Exclusions

The following are specifically excluded from Mental Health and Substance Abuse Services:

- Any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless Medically Necessary and otherwise covered under this policy or agreement.
- Treatment of disorders which have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain.
- Developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders.
- Counseling for activities of an educational nature.
- Counseling for borderline intellectual functioning.
- Counseling for occupational problems.
- Counseling related to consciousness raising.
- Vocational or religious counseling.
- I.Q. testing.
- Custodial care, including but not limited to geriatric day care.
- Psychological testing on children requested by or for a school system.
- Occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline.
- Residential Treatment Services

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Durable Medical Equipment

- Charges made for purchase or rental of Durable Medical Equipment that is ordered or prescribed by a Physician and provided by a vendor approved by CG for use outside a Hospital or Other Health Care Facility. Coverage for repair, replacement or duplicate equipment is provided only when required due to anatomical change and/or reasonable wear and tear. All maintenance and repairs that result from a person's misuse are the person's responsibility. Coverage for Durable Medical Equipment is limited to the lowest-cost alternative as determined by the utilization review Physician.

  Durable Medical Equipment is defined as items which are designed for and able to withstand repeated use by more than one person; customarily serve a medical purpose; generally are not useful in the absence of Injury or Sickness; are appropriate for use in the home; and are not disposable. Such equipment includes, but is not limited to, crutches, hospital beds, respirators, wheel chairs, and dialysis machines.

  Durable Medical Equipment items that are not covered include but are not limited to those that are listed below:

  - **Bed Related Items:** bed trays, over the bed tables, bed wedges, pillows, custom bedroom equipment, mattresses, including nonpower mattresses, custom mattresses and posturepedic mattresses.
  - **Bath Related Items:** bath lifts, nonportable whirlpools, bathtub rails, toilet rails, raised toilet seats, bath benches, bath stools, hand held showers, paraffin baths, bath mats, and spas.
  - **Chairs, Lifts and Standing Devices:** computerized or gyroscopic mobility systems, roll about chairs, geriatric chairs, hip chairs, seat lifts (mechanical or motorized), patient lifts (mechanical or motorized – manual hydraulic lifts are covered if patient is two-person transfer), and auto tilt chairs.
  - **Fixtures to Real Property:** ceiling lifts and wheelchair ramps.
  - **Car/Van Modifications**.
  - **Air Quality Items:** room humidifiers, vaporizers, air purifiers and electrostatic machines.
  - **Blood/Injection Related Items:** blood pressure cuffs, centrifuges, nova pens and needleless injectors.
  - **Other Equipment:** heat lamps, heating pads, cryounits, cryotherapy machines, electronic-controlled therapy units, ultraviolet cabinets, sheepskin pads and boots, postural drainage board, AC/DC adaptors, enuresis alarms, magnetic equipment, scales (baby and adult), stair gliders, elevators, saunas, any exercise equipment and diathermy machines.

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External Prosthetic Appliances and Devices

- Charges made or ordered by a Physician for: the initial purchase and fitting of external prosthetic appliances and devices available only by prescription which are necessary for the alleviation or correction of Injury, Sickness or congenital defect. Coverage for External Prosthetic Appliances is limited to the most appropriate and cost effective alternative as determined by the utilization review Physician.

  External prosthetic appliances and devices shall include prostheses/prosthetic appliances and devices, orthoses and orthotic devices; braces; and splints.

Prostheses/Prosthetic Appliances and Devices

Prostheses/prosthetic appliances and devices are defined as fabricated replacements for missing body parts. Prostheses/prosthetic appliances and devices include, but are not limited to:

- basic limb prostheses;
- terminal devices such as hands or hooks; and
- speech prostheses.

Orthoses and Orthotic Devices

Orthoses and orthotic devices are defined as orthopedic appliances or apparatuses used to support, align, prevent or correct deformities. Coverage is provided for custom foot orthoses and other orthoses as follows:

- Nonfoot orthoses – only the following nonfoot orthoses are covered:
  - rigid and semirigid custom fabricated orthoses,
  - semirigid prefabricated and flexible orthoses; and
  - rigid prefabricated orthoses including preparation, fitting and basic additions, such as bars and joints.
- Custom foot orthoses – custom foot orthoses are only covered as follows:
  - for persons with impaired peripheral sensation and/or altered peripheral circulation (e.g. diabetic neuropathy and peripheral vascular disease);
  - when the foot orthosis is an integral part of a leg brace and is necessary for the proper functioning of the brace;
  - when the foot orthosis is for use as a replacement or substitute for missing parts of the foot (e.g. amputated toes) and is necessary for the alleviation or correction of Injury, Sickness or congenital defect; and
  - for persons with neurologic or neuromuscular condition (e.g. cerebral palsy, hemiplegia, spina bifida) producing spasticity, malalignment, or pathological positioning of the foot and there is reasonable expectation of improvement.

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The following are specifically excluded orthoses and orthotic devices:

- prefabricated foot orthoses;
- cranial banding and/or cranial orthoses. Other similar devices are excluded except when used postoperatively for synostotic plagiocephaly. When used for this indication, the cranial orthosis will be subject to the limitations and maximums of the External Prosthetic Appliances and Devices benefit;
- orthosis shoes, shoe additions, procedures for foot orthopedic shoes, shoe modifications and transfers;
- orthoses primarily used for cosmetic rather than functional reasons; and
- orthoses primarily for improved athletic performance or sports participation.

Braces

A Brace is defined as an orthosis or orthopedic appliance that supports or holds in correct position any movable part of the body and that allows for motion of that part.

The following braces are specifically excluded: Copes scoliosis braces.

Splints

A Splint is defined as an appliance for preventing movement of a joint or for the fixation of displaced or movable parts.

Coverage for replacement of external prosthetic appliances and devices is limited to the following:

- Replacement due to regular wear. Replacement for damage due to abuse or misuse by the person will not be covered.
- Replacement will be provided when anatomic change has rendered the external prosthetic appliance or device ineffective. Anatomic change includes significant weight gain or loss, atrophy and/or growth.
- Coverage for replacement is limited as follows:
  - No more than once every 24 months for persons 19 years of age and older and
  - No more than once every 12 months for persons 18 years of age and under.
  - Replacement due to a surgical alteration or revision of the site.

The following are specifically excluded external prosthetic appliances and devices:

- External and internal power enhancements or power controls for prosthetic limbs and terminal devices; and
- Myoelectric prostheses peripheral nerve stimulators.

GM6000 05BPT5

Short-Term Rehabilitative Therapy

Short-term Rehabilitative Therapy that is part of a rehabilitation program, including physical, speech, occupational, cognitive, osteopathic manipulative, cardiac rehabilitation and pulmonary rehabilitation therapy, when provided in the most medically appropriate setting.

The following limitation applies to Short-term Rehabilitative Therapy:

- Occupational therapy is provided only for purposes of enabling persons to perform the activities of daily living after an Illness or Injury or Sickness.

Short-term Rehabilitative Therapy services that are not covered include but are not limited to:

- Sensory integration therapy, group therapy; treatment of dyslexia; behavior modification or myofunctional therapy for dysfluency, such as stuttering or other involuntarily acted conditions without evidence of an underlying medical condition or neurological disorder;
- Treatment for functional articulation disorder such as correction of tongue thrust, lisp, verbal apraxia or swallowing dysfunction that is not based on an underlying diagnosed medical condition or Injury; and
- Maintenance or preventive treatment consisting of routine, long-term or non-Medically Necessary care provided to prevent recurrence or to maintain the patient's current status;

A separate Copayment will apply to the services provided by each provider.

These services will also include habilitative services (including developmental speech therapy) for the treatment of children under age 19 with congenital and genetic birth defects to enhance the child's ability to function. Congenital and genetic birth defects are described as a defect existing at or from birth, including a hereditary defect as well as autism or an autism spectrum disorder; and cerebral palsy. Otherwise, excludes therapy to improve speech skills that have not fully developed (except when speech is not fully developed in children due to an underlying disease or malformation that prevented speech development); therapy intended to maintain speech communication; or therapy not restorative in nature.

Services that are provided by a chiropractic Physician are not covered.

These services include the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to restore motion, reduce pain and improve function.

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Chiropractic Care Services

Charges made for diagnostic and treatment services utilized in an office setting by chiropractic Physicians. Chiropractic treatment includes the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain, and improve function. For these services you have direct access to qualified chiropractic Physicians.

The following limitation applies to Chiropractic Care Services:

- Occupational therapy is provided only for purposes of enabling persons to perform the activities of daily living after an Injury or Sickness;

Chiropractic Care services that are not covered include but are not limited to:

- services of a chiropractor which are not within his scope of practice, as defined by state law;
- charges for care not provided in an office setting;
- maintenance or preventive treatment consisting of routine, longterm or non-Medically Necessary care provided to prevent recurrence or to maintain the patient's current status; and
- vitamin therapy.

GM6000 07BNR4

Transplant Services (All Transplant Services require pre-authorization)

Note: Contact 1-800-633--8519 (Actives) or 1-800-942-6724 (Retirees) for pre-authorization and case management services for organ transplant services.

- Charges made for human organ and tissue transplant services which include solid organ and bone marrow/stem cell procedures at designated facilities throughout the United States or its territories. This coverage is subject to the following conditions and limitations.

  Transplant services include the recipient's medical, surgical and Hospital services; inpatient immunosuppressive medications; and costs for organ or bone marrow/stem cell procurement. Transplant services are covered only if they are required to perform any of the following human to human organ or tissue transplants: allogeneic bone marrow/stem cell, autologous bone marrow/stem cell, cornea, heart/lung, kidney, kidney/pancreas, liver, lung, pancreas or intestine which includes small bowel, liver or multiple viscera.

  All Transplant services, other than cornea, are payable at 100% when received at CIGNA LIFESOURCE Transplant Network® Facilities. Cornea transplants are not covered at CIGNA LIFESOURCE Transplant Network® facilities. Transplant services, including cornea, when received from Participating Provider facilities other than CIGNA LIFESOURCE Transplant Network® facilities are payable at the In-Network level. **Transplant services received at any other facilities are not covered.**

  Coverage for organ procurement costs are limited to costs directly related to the procurement of an organ, from a cadaver or a live donor. Organ procurement costs shall consist of surgery necessary for organ removal, organ transportation and the transportation, hospitalization and surgery of a live donor. Compatibility testing undertaken prior to procurement is covered if Medically Necessary. Costs related to the search for, and identification of a bone marrow or stem cell donor for an allogeneic transplant are also covered.

Transplant Travel Services

Charges made for reasonable travel expenses incurred by you in connection with a preapproved organ/tissue transplant are covered subject to the following conditions and limitations. Transplant travel benefits are not available for cornea transplants. Benefits for transportation, lodging and food are available to you only if you are the recipient of a preapproved organ/tissue transplant from a designated CIGNA LIFESOURCE Transplant Network® facility. The term recipient is defined to include a person receiving authorized transplant related services during any of the following: (a) evaluation, (b) candidacy, (c) transplant event, or (d) post-transplant care. Travel expenses for the person receiving the transplant will include charges for: transportation to and from the transplant site (including charges for a rental car used during a period of care at the transplant facility); lodging while at, or traveling to and from the transplant site; and food while at, or traveling to and from the transplant site.

In addition to your coverage for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver.

The following are specifically excluded travel expenses:

Travel costs incurred due to travel within 60 miles of your home; laundry bills; telephone bills; alcohol or tobacco products; and charges for transportation that exceed coach class rates.

These benefits are only available when the Covered Person is the recipient of an organ transplant. No benefits for travel expenses are available when the Covered Person is a donor.

GM6000 05BPT7 V7

Breast Reconstruction and Breast Prostheses

- Charges made for reconstructive surgery following a mastectomy; benefits include: (a) surgical services for reconstruction of the breast on which surgery was performed; (b) surgical services for reconstruction of the nondiseased breast to produce symmetrical appearance; (c) postoperative breast prostheses; and (d) mastectomy bras and external prosthetics, limited to the lowest cost alternative available that meets external prosthetic placement needs. During all stages of mastectomy, treatment of physical complications, including lymphedema therapy, are covered.

Reconstructive Surgery

- Charges made for reconstructive surgery or therapy to repair or correct a severe physical deformity or disfigurement which is accompanied by functional deficit; (other than abnormalities of the jaw or conditions related

to TMJ disorder) provided that: (a) the surgery or therapy restores or improves function; (b) reconstruction is required as a result of Medically Necessary, noncosmetic surgery; or (c) the surgery or therapy is performed prior to age 19 and is required as a result of the congenital absence or agenesis (lack of formation or development) of a body part. Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement as determined by the utilization review Physician.

GM6000 05BPT2 V2

Prescription Drug Benefits

The Schedule

For You and Your Dependents

This plan provides Prescription Drug benefits for Prescription Drugs and Related Supplies provided by Pharmacies as shown in this Schedule. To receive Prescription Drug Benefits, you and your Dependents may be required to pay a portion of the Covered Expenses for Prescription Drugs and Related Supplies for each 30-day supply or each 90-day supply at a participating retail pharmacy. That portion is the Copayment.

Copayments

Copayments are expenses to be paid by you or your Dependent for covered Prescription Drugs and Related Supplies.

BENEFIT HIGHLIGHTS	PARTICIPATING PHARMACY	Non-PARTICIPATING PHARMACY
Prescription Drugs		
Tier One Generic* drugs on the Prescription Drug List	$10 per prescription order or refill, then 100% coverage for up to 30-day supply $30 per prescription order or refill, then 100% coverage for up to 90-day supply of maintenance medications	$10 per prescription order or refill, then 100% coverage for up to 30-day supply**
Tier Two Brand-Name* drugs designated as preferred on the Prescription Drug List	$30 per prescription order or refill, then 100% coverage for up to 30-day supply $90 per prescription order or refill, then 100% coverage for up to 90-day supply of maintenance medications	$30 per prescription order or refill, then 100% coverage for up to 30-day supply**
Tier Three Brand-Name* drugs with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List	$100 per prescription order or refill, then 100% coverage for up to 30-day supply $300 per prescription order or refill, then 100% coverage for up to 90-day supply of maintenance medications	$100 per prescription order or refill, then 100% coverage for up to 30-day supply**

*Designated as per generally-accepted industry sources and adopted by CG

**Out of Network coverage is limited to the contracted amount

Note: If the physician does not write DAW on the prescription, but the Member desires and/or requests the brand drug when a generic is available, the Member pays the applicable brand copay plus the difference in cost between the brand and generic if a generic equivalent is available (up to the cost of the brand-name drug).

Prescription Drug Benefits

For You and Your Dependents

Covered Expenses

If you or any one of your Dependents, while insured for Prescription Drug Benefits, incurs expenses for charges made by a Pharmacy, for Medically Necessary Prescription Drugs or Related Supplies ordered by a Physician, CG will provide coverage for those expenses as shown in the Schedule. Coverage also includes Medically Necessary Prescription Drugs and Related Supplies dispensed for a prescription issued to you or your Dependents by a licensed dentist for the prevention of infection or pain in conjunction with a dental procedure.

When you or a Dependent is issued a prescription for Medically Necessary Prescription Drugs or Related Supplies as part of the rendering of Emergency Services and that prescription cannot reasonably be filled by a Participating Pharmacy, the prescription will be covered by CG, as if filled by a Participating Pharmacy.

Limitations

Each Prescription Order or refill shall be limited as follows:

- up to a consecutive 30-day supply, at a retail Pharmacy, unless limited by the drug manufacturer's packaging;
- up to a consecutive 90-day supply for a maintenance medication, at a participating (or in-network) retail Pharmacy, unless limited by the drug manufacturer's packaging or
- to a dosage and/or dispensing limit as determined by the P&T Committee.

GM6000 PHARM91

GM6000 PHARM85 PHARM114

Coverage for certain Prescription Drugs and Related Supplies requires your Physician to obtain authorization prior to prescribing. If the request is approved, your Physician will receive confirmation. The authorization will be processed in our claim system to allow you to have coverage for those Prescription Drugs or Related Supplies. The length of the authorization will depend on the diagnosis and Prescription Drugs or Related Supplies. When your Physician advises you that coverage for the Prescription Drugs or Related Supplies has been approved, you should contact the Pharmacy to fill the prescription(s).

If the request is denied, your Physician and you will be notified that coverage for the Prescription Drugs or Related Supplies is not authorized.

If you disagree with a coverage decision, you may appeal that decision in accordance with the provisions of the Policy, by submitting a written request stating why the Prescription Drugs or Related Supplies should be covered.

Written appeals and inquiries related to the Prescription Drug Program should be directed to:

CIGNA Healthcare
P.O. Box 188050
Chattanooga, TN 37422-8050

If you have questions about a specific prior authorization request, you should call Member Services at 1-800-633--8519 (Actives) or 1-800-942-6724 (Retirees). For details regarding how to file an appeal, please refer to the section titled, When You Have a Complaint or an Appeal on a following page.

Note: Tier status will not be overridden or changed on an individual basis.

All drugs newly approved by the Food and Drug Administration (FDA) are designated as either non-Preferred or non-Prescription Drug List drugs until the P & T Committee clinically evaluates the Prescription Drug for a different designation.

In addition, prescription drugs that have an equally effective and less costly generic-equivalent are designated as non-Preferred drugs.

Prescription Drugs that represent an advance over available therapy according to the FDA will be reviewed by the P&T Committee within six months after FDA approval. Prescription Drugs that appear to have therapeutic qualities similar to those of an already marketed drug according to the FDA, will not be reviewed by the P&T Committee for at least six months after FDA approval. In the case of compelling clinical data, an ad hoc group will be formed to make an interim decision on the merits of a Prescription Drug.

Your Payments

Coverage for Prescription Drugs and Related Supplies purchased at a Pharmacy is subject to the Copayment or Coinsurance shown in the Prescription Drug Benefits Schedule. Please refer to the Schedule for any required Copayments.

When a treatment regimen contains more than one type of Prescription Drug which are packaged together for your, or your Dependent's convenience, a Copayment will apply to each Prescription Drug.

GM6000 PHARM129 V1

Prescription Drug Program Exclusions

No payment will be made for the following expenses:

- Drugs available over the counter that do not require a prescription by federal or state law;
- Any drug that is a pharmaceutical alternative to an over-the-counter drug other than insulin;
- A drug class in which at least one of the drugs is available over the counter and the drugs in the class are deemed to be therapeutically equivalent as determined by the P&T Committee;
- Injectable infertility drugs and any injectable drugs that require Physician supervision and are not typically considered self-administered drugs. The following are examples of Physician supervised drugs: Injectables used to treat hemophilia and RSV (respiratory syncytial virus), chemotherapy injectables and endocrine and metabolic agents.
- Any drugs that are experimental or investigational as described under the Medical "Exclusions" section of your certificate;
- Food and Drug Administration (FDA) approved drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia (The United States Pharmacopeia Drug Information, The American Medical Association Drug Evaluations; or The American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in a peer-reviewed national professional medical journal;
- Prescription and nonprescription supplies (such as ostomy supplies), devices, and appliances other than Related Supplies;
- Implantable contraceptive products;
- Any fertility drug;
- Dietary supplements;
- Drugs used for cosmetic purposes such as drugs used to reduce wrinkles, drugs to promote hair growth as well as drugs used to control perspiration and fade cream products;
- Diet pills or appetite suppressants (anorectics);
- Prescription smoking cessation products;
- Immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis;
- Replacement of Prescription Drugs and Related Supplies due to loss or theft;
- Drugs used to enhance athletic performance;
- Drugs which are to be taken by or administered to you while you are a patient in a licensed Hospital, Rehabilitation Hospital (Long Term Acute Care Facility), Skilled Nursing Facility, rest home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals;
- Prescriptions more than one year from the original date of issue.

- Other limitations are shown in the Medical "Exclusions" section.

GM6000 PHARM88
GM6000 PHARM89
GM6000 PHARM105

PHARM104V16

Reimbursement/Filing a Claim

When you or your Dependents purchase your Prescription Drugs or Related Supplies through a retail Participating Pharmacy, you pay any applicable Copayment shown in the Schedule at the time of purchase. You do not need to file a claim form for Participating Retail Pharmacies.

Reimbursement for Non-Participating Pharmacies will be limited to the Participating Pharmacy contracted rate.

If you or your Dependents purchase your Prescription Drugs or Related Supplies through a non-Participating Pharmacy, you pay the full cost at the time of purchase. You must submit a claim form to be reimbursed.

See your Employer's Benefit Plan Administrator or visit myCIGNA.com to obtain the appropriate claim form.

Coordination of Benefits With Prescription Drugs

If your spouse or a dependent has primary coverage from another health plan, prescription drug benefits provided by the State Health Benefit Plan (SHBP) will be coordinated with the other insurance carrier(s). This means you must first use your primary insurance plan when you pay for your prescription(s). To request a secondary payment from CIGNA at the time of purchase you can request the Pharmacist to electronically file SHBP secondary. By mail you can send a claim form and attach a copy of the Explanation of Benefits (EOB) form from the primary plan and the pharmacy receipt. You can obtain a claim form at myCIGNA.com or www.dch.georgia.gov.

Secondary payments are subject to network allowed amounts for covered drugs. Under the SHBP plan, you will be responsible for the appropriate copays reflected in the Prescription Drug Benefits Schedule. In the event that your primary plan copays are less than the copays under the SHBP plan, no secondary payment will be allowed. Please contact CIGNA at the Customer Care number on your State Health Benefit Plan ID card for more details.

If you have coverage under two State Health Benefit Plan contracts (cross-coverage) prescription drug benefits provided by the State Health Benefit Plan will not be coordinated.

What should I do if I use a self-administered injectable medication?

You may have coverage for self-administered injectable medications through your pharmacy benefit plan or under your medical benefits.

Please call our Customer Care number on your ID card to determine whether or not a medication is covered as a self-administered injectable under your pharmacy or medical benefits.

How do I obtain a supply of my medications before I go on vacation?

Vacation overrides are allowed for Members to have up to a 3 month supply of medication in their possession. If someone is leaving the country for an extended period of time for work or a student studying abroad, we will allow multiple months to process at one copay per month, up to one year. This does not apply to extended vacations. If the member's eligibility status will change as a result of working or studying abroad the Member is not eligible for an extended override.

You may also locate a network pharmacy at your vacation destination through the Internet at myCIGNA.com or by calling the Customer Care number on your ID card.

How do I access updated information about my pharmacy benefit?

Since the Prescription Drug List may change periodically, we encourage you to visit myCIGNA.com or please call our Customer Care number on your ID card for more current information.

Log on to myCIGNA.com for the following pharmacy resources and tools:

- Pharmacy benefit and coverage information
- Specific copayment amounts for prescription medications
- Possible lower-cost medication alternatives

- A list of medications based on a specific medical condition
- Medication interactions and side effects, etc.
- Locate a participating retail pharmacy by zip code
- Review your prescription history

What if I still have questions?

Please call our Customer Care number on your ID card. Representatives are available to assist you 24 hours a day, except Thanksgiving and Christmas.

GM6000 PHARM94 V17

CIGNA Vision

The Schedule

For You and Your Dependents

Benefits Include:

Examinations – One vision and eye health evaluation including but not limited to eye health examination, dilation, refraction and prescription for glasses.

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Examinations Limited to one exam, including refraction, every 24 months	90% of Covered Expenses, no deductible	In-Network coverage only

CIGNA Vision Benefits

Covered Expenses

The Schedule of Vision Benefits that accompanies your certificate booklet lists covered services.

CG will pay for covered services incurred by you and your eligible Dependents subject to: frequency limits; benefit maximums; cost sharing provisions; and limitations as set forth in the Schedule of Vision Benefits.

GM6000 VISION4

Expenses Not Covered

Covered Expenses will not include, and no payment will be made for:

- Orthoptic or vision training and any associated supplemental testing.
- Spectacle lens treatments, “add ons”, or lens coatings not shown as covered in the Schedule.
- Two pair of glasses, in lieu of bifocals or trifocals.
- Prescription sunglasses.
- Medical or surgical treatment of the eyes.
- Any eye examination, or any corrective eyewear, required by an employer as a condition of employment.
- Magnification or low vision aids.
- Any prescription or non-prescription eyeglasses, lenses, or contact lenses.
- Safety glasses or lenses required for employment.
- VDT (video display terminal)/ computer eyeglass benefit.
- Charges in excess of the Maximum Reimbursable Charge for the Service or Materials.
- Charges incurred after the Policy ends or the Insured's coverage under the Policy ends, except as stated in the Policy.
- Experimental or non-conventional treatment or device.
- High Index lenses of any material type.
- For or in connection with experimental procedures or treatment methods not approved by the American Optometric Association or the appropriate vision specialty society.

Other Limitations are shown in the "General Limitation and Exclusions" section.

GM6000 VISION5 V1

General Limitations and Exclusions

Applicable to All Coverages

Additional coverage limitations determined by plan or provider type are shown in the Schedule. Payment for the following is specifically excluded from this plan:

- Expenses for supplies, care, treatment, or surgery that are not Medically Necessary.
- To the extent that you or any one of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid.
- To the extent that payment is unlawful where the person resides when the expenses are incurred.
- Charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected Injury or Sickness.
- For or in connection with an Injury or Sickness which is due to war, declared or undeclared.
- Charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan.
- Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- For or in connection with experimental, investigational or unproven services.

  Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the utilization review Physician to be:

  - not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed;
  - not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;
  - the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" section of this plan; or
  - the subject of an ongoing phase I, II or III clinical trial, except as provided in the "Clinical Trials" section of this plan.
- Cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.
- Regardless of clinical indication for gynecomastia surgeries; abdominoplasty/panniculectomy; rhinoplasty; redundant skin surgery; removal of skin tags; acupressure; craniosacral/cranial therapy; dance therapy; movement therapy; applied kinesiology; rolfing; prolotherapy; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- For or in connection with treatment of the teeth or periodontium unless such expenses are incurred for: (a) charges made for a continuous course of dental treatment started within six months of an Injury to sound natural teeth; (b) charges made by a Hospital for Bed and Board or Necessary Services and Supplies; or (c) charges made by a Free-Standing Surgical Facility or the outpatient department of a Hospital in connection with surgery.
- For medical and surgical services, initial and repeat, intended for the treatment or control of obesity including clinically severe (morbid) obesity, including: medical and surgical services to alter appearance or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.
- Unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
- Court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.

- Infertility services including infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage.
- Reversal of male and female voluntary sterilization procedures.
- Transsexual surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
- Any medications, drugs, services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy, and premature ejaculation.
- Medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.
- Nonmedical counseling or ancillary services, including but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other nonmedical ancillary services for the treatment of learning disabilities, developmental delays, autism or mental retardation. Nonmedical ancillary services DOES NOT include services such as physical therapy, speech therapy and occupational therapy.
- Behavioral therapies that are considered experimental, investigational or unproven are excluded and are non-covered services for treatment of any condition.
- Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the “Home Health Services” or “Breast Reconstruction and Breast Prostheses” sections of this plan.
- Private Hospital rooms and/or private duty nursing except as provided under the Home Health Services provision.
- Personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
- Artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs, unless provided for hair loss as a result of cancer treatment/chemotherapy.
- Hearing aids, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.
- Aids or devices that assist with nonverbal communications, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- Medical benefits for eyeglasses, contact lenses or examinations for prescription or fitting thereof, except that Covered Expenses will include the purchase of the first pair of eyeglasses, lenses, frames or contact lenses that follows keratoconus or cataract surgery.
- Charges made for eye exercises and for surgical treatment for the correction of a refractive error, including radial keratotomy, when eyeglasses or contact lenses may be worn.
- All noninjectable prescription drugs, injectable prescription drugs that do not require Physician supervision and are typically considered self-administered drugs, nonprescription drugs, and investigational and experimental drugs, except as provided in this plan.
- Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
- Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.

- Genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- Dental implants, unless provided as a result of damage from radiation or chemotherapy treatment and prior approved by CIGNA.
- Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- Blood administration for the purpose of general improvement in physical condition.
- Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- Cosmetics, dietary supplements and health and beauty aids.
- Nutritional supplements and formulae except for infant formula needed for the treatment of inborn errors of metabolism.
- Medical treatment for a person age 65 or older, who is covered under this plan as a retiree, or their Dependent, when payment is denied by the Medicare plan because treatment was received from a nonparticipating provider.
- Medical treatment when payment is denied by a Primary Plan because treatment was received from a nonparticipating provider.
- For or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- Telephone, e-mail, and Internet consultations, and telemedicine.
- Massage therapy.
- For charges which would not have been made if the person had no insurance.
- To the extent that they are more than Maximum Reimbursable Charges.
- Charges made by any covered provider who is a member of your family or your Dependent's family.
- To the extent of the exclusions imposed by any certification requirement shown in this plan.

GM6000 05BPT14 V143
GM6000 05BPT105
GM6000 06BNR2V2
GM6000 06BNR2 V88

Coordination of Benefits

This section applies if you or any one of your Dependents is covered under more than one Plan and determines how benefits payable from all such Plans will be coordinated. You should file all claims with each Plan.

Definitions

For the purposes of this section, the following terms have the meanings set forth below:

Plan

Any of the following that provides benefits or services for medical care or treatment:

(1) Group insurance and/or group-type coverage, whether insured or self-insured which neither can be purchased by the general public, nor is individually underwritten, including closed panel coverage.

(2) Coverage under Medicare and other governmental benefits as permitted by law, excepting Medicaid and Medicare supplement policies; or Workers' Compensation policies.

(3) Medical benefits coverage of group, group-type, and individual automobile contracts.

Each Plan or part of a Plan which has the right to coordinate benefits will be considered a separate Plan.

Closed Panel Plan

A Plan that provides medical or dental benefits primarily in the form of services through a panel of employed or contracted providers, and that limits or excludes benefits provided by providers outside of the panel, except in the case of emergency or if referred by a provider within the panel.

Primary Plan

The Plan that determines and provides or pays benefits without taking into consideration the existence of any other Plan.

Secondary Plan

A Plan that determines, and may reduce its benefits after taking into consideration, the benefits provided or paid by the Primary Plan. A Secondary Plan may also recover from the Primary Plan the Reasonable Cash Value of any services it provided to you.

GM6000 COB11

Allowable Expense

A necessary, reasonable and customary service or expense, including deductibles, coinsurance, that is covered in full or in part by any Plan covering you. When a Plan provides benefits in the form of services, the Reasonable Cash Value of each service is the Allowable Expense and is a paid benefit.

Examples of expenses or services that are not Allowable Expenses include, but are not limited to the following:

(1) An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense.

(2) If you are confined to a private Hospital room and no Plan provides coverage for more than a semiprivate room, the difference in cost between a private and semiprivate room is not an Allowable Expense.

(3) If you are covered by two or more Plans that provide services or supplies on the basis of reasonable and customary fees, any amount in excess of the highest reasonable and customary fee is not an Allowable Expense.

(4) If you are covered by one Plan that provides services or supplies on the basis of reasonable and customary fees and one Plan that provides services and supplies on the basis of negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.

(5) If your benefits are reduced under the Primary Plan (through the imposition of a higher coinsurance percentage, a deductible and/or a penalty) because you did not comply with Plan provisions or because you did not use a preferred

provider, the amount of the reduction is not an Allowable Expense. Such Plan provisions include second surgical opinions and precertification of admissions or services.

Claim Determination Period

A calendar year, but does not include any part of a year during which you are not covered under this policy or any date before this section or any similar provision takes effect.

GM6000 COB12

Reasonable Cash Value

An amount which a duly licensed provider of health care services usually charges patients and which is within the range of fees usually charged for the same service by other health care providers located within the immediate geographic area where the health care service is rendered under similar or comparable circumstances.

Order of Benefit Determination Rules

A Plan that does not have a coordination of benefits rule consistent with this section shall always be the Primary Plan. If the Plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation is the one to use:

(1) The Plan that covers you as an enrollee or an employee shall be the Primary Plan and the Plan that covers you as a Dependent shall be the Secondary Plan;

(2) If you are a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the calendar year as an enrollee or employee;

(3) If you are the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:

(a) first, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;

(b) then, the Plan of the parent with custody of the child;

(c) then, the Plan of the spouse of the parent with custody of the child;

(d) then, the Plan of the parent not having custody of the child, and

(e) finally, the Plan of the spouse of the parent not having custody of the child.

GM6000 COB13

(4) The Plan that covers you as an active employee (or as that employee's Dependent) shall be the Primary Plan and the Plan that covers you as laid-off or retired employee (or as that employee's Dependent) shall be the secondary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.

(5) The Plan that covers you under a right of continuation which is provided by federal or state law shall be the Secondary Plan and the Plan that covers you as an active employee or retiree (or as that employee's Dependent) shall be the Primary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.

(6) If one of the Plans that covers you is issued out of the state whose laws govern this Policy, and determines the order of benefits based upon the gender of a parent, and as a result, the Plans do not agree on the order of benefit determination, the Plan with the gender rules shall determine the order of benefits.

If none of the above rules determines the order of benefits, the Plan that has covered you for the longer period of time shall be primary.

When coordinating benefits with Medicare, this Plan will be the Secondary Plan and determine benefits after Medicare, where permitted by the Social Security Act of 1965, as amended. However, when more than one Plan is secondary to Medicare, the benefit determination rules identified above, will be used to determine how benefits will be coordinated.

Effect on the Benefits of This Plan

If this Plan is the Secondary Plan, this Plan may reduce benefits so that the total benefits paid by all Plans during a Claim Determination Period are not more than 100% of the total of all Allowable Expenses.

GM6000 COB14M

The difference between the amount that this Plan would have paid if this Plan had been the Primary Plan, and the benefit payments that this Plan had actually paid as the Secondary Plan, will be recorded as a benefit reserve for you. CG will use this benefit reserve to pay any Allowable Expense not otherwise paid during the Claim Determination Period.

GM6000 COB14

As each claim is submitted, CG will determine the following:

(1) CG's obligation to provide services and supplies under this policy;

(2) whether a benefit reserve has been recorded for you; and

(3) whether there are any unpaid Allowable Expenses during the Claims Determination Period.

If there is a benefit reserve, CG will use the benefit reserve recorded for you to pay up to 100% of the total of all Allowable Expenses. At the end of the Claim Determination Period, your benefit reserve will return to zero and a new benefit reserve will be calculated for each new Claim Determination Period.

Recovery of Excess Benefits

If CG pays charges for benefits that should have been paid by the Primary Plan, or if CG pays charges in excess of those for which we are obligated to provide under the Policy, CG will have the right to recover the actual payment made or the Reasonable Cash Value of any services.

CG will have sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments made by any insurance company, healthcare plan or other organization. If we request, you must execute and deliver to us such instruments and documents as we determine are necessary to secure the right of recovery.

Right to Receive and Release Information

CG, without consent or notice to you, may obtain information from and release information to any other Plan with respect to you in order to coordinate your benefits pursuant to this section. You must provide us with any information we request in order to coordinate your benefits pursuant to this section. This request may occur in connection with a submitted claim; if so, you will be advised that the "other coverage" information, (including an Explanation of Benefits paid under the Primary Plan) is required before the claim will be processed for payment. If no response is received within 90 days of the request, the claim will be denied. If the requested information is subsequently received, the claim will be processed.

GM6000 COB15

Subrogation and Reimbursement

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. If you receive a benefit payment from the Plan for an Injury caused by a third party, and you later receive any payment for that same condition or Injury from another person, organization or insurance company, we have the right to recover any payments made by the Plan to you. This process of recovering earlier payments is called subrogation. In case of subrogation, you may be asked to sign and deliver information or documents necessary for us to protect our right to recover benefit payments made. You agree to provide us all assistance necessary as a condition of participation in the Plan, including cooperation and information submitted to as supplied by a workers' compensation, liability insurance carrier, and any medical benefits, no-fault insurance, or school insurance coverage that are paid or payable.

We shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type, for the reasonable value of services and benefits we provided to you from any or all of the following:

Third parties, including any person alleged to have caused you to suffer injuries or damages.

- Your employer.
- Any person or entity obligated to provide benefits or payments to you.

You agree as follows:

- To cooperate with us in protecting our legal rights to subrogation and reimbursement.
- That our rights will be considered as the first priority claim against Third Parties, to be paid before any other of your claims are paid.
- That we may, at our option, take necessary and appropriate action to preserve our rights under these subrogation provisions.
- To execute and deliver such documents including consent to release medical records, and provide such help (including responding to requests for information about any accident or injuries and making court appearances) as we may reasonably request from you.
- You will do nothing to prejudice our rights under this provision, either before or after the need for services or benefits under the Plan.

Refund of Overpayments

If we pay benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to us if either of the following apply:

- All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment we made exceeded the benefits under the Plan.

The refund equals the amount we paid in excess of the amount we should have paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help us get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future benefits that are payable under the Plan. The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.

Payment of Benefits

To Whom Payable

All Medical benefits are payable to you. However, at the option of CG, all or any part of them may be paid directly to the person or institution on whose charge claim is based.

Medical benefits are not assignable unless agreed to by CG. CG may, at its option, make payment to you for the cost of any Covered Expenses received by you or your Dependent from a Non-Participating Provider even if benefits have been assigned. When benefits are paid to you or your Dependent, you or your Dependent is responsible for reimbursing the Provider. If any person to whom benefits are payable is a minor or, in the opinion of CG, is not able to give a valid receipt for any payment due him, such payment will be made to his legal guardian. If no request for payment has been made by his legal guardian, CG may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

If you die while any of these benefits remain unpaid, CG may choose to make direct payment to any of your following living relatives: spouse, mother, father, child or children, brothers or sisters; or to the executors or administrators of your estate.

Payment as described above will release CG from all liability to the extent of any payment made.

Time of Payment

Benefits will be paid by CG when it receives due proof of loss. All claims must be filed within twenty-four (24) months of the date of service.

Recovery of Overpayment

When an overpayment has been made by CG, CG will have the right at any time to: (a) recover that overpayment from the person to whom or on whose behalf it was made; or (b) offset the amount of that overpayment from a future claim payment.

Calculation of Covered Expenses

CG, in its discretion, will calculate Covered Expenses following evaluation and validation of all provider billings in accordance with:

- the methodologies in the most recent edition of the Current Procedural terminology.
- the methodologies as reported by generally recognized professionals or publications.

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Termination of Insurance

General Information about When Coverage Ends

We may discontinue this benefit Plan and/or all similar benefit plans at any time.

Your entitlement to benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, we will still pay claims for Covered Health Services that you received before your coverage ended. However, once your coverage ends, we do not provide benefits for health services that you receive for medical conditions that occurred after your coverage ended, even if the underlying medical condition occurred before your coverage ended.

An Enrolled Dependent's coverage ends on the date the Member's coverage ends.

When Coverage Ends For You

Your coverage generally will end if:

- you no longer qualify under any category listed under the eligibility rules and your payroll deductions for coverage have ceased;
- you do not make direct-pay premium payments on time;
- you resign or otherwise end your employment;
- you are laid off because of a formal plan to reduce staff;
- your hours are reduced so that you are no longer benefits eligible;
- you do not return to active work after an approved unpaid leave of absence; or
- you are terminated by your employer.

Coverage for Member ends at the end of the month following the month in which the last premium is deducted from your earned paycheck or at the end of paid coverage. Premiums will not be deducted from final leave pay.

Note: If an Employing Entity fails to remit Premiums or documentation or fails to reconcile bills in the manner required by the Plan, the Plan may suspend benefit payments for Enrolled Members of the Employing Entity. Suspended coverage is not a COBRA event; however, the Member may continue coverage if the Member is eligible for continuation of coverage rights as defined in COBRA Continuation Rights Under Federal Law and pays both the employer and employee share of the cost.

When Coverage May Be Continued For You

SHBP allows individuals to continue their SHBP coverage in certain situations when it would have otherwise ended.

If you have this situation…	You will be affected in this way:
Leave your job with less than 8 years of services…	You may continue coverage for up to 18 months under COBRA provisions.
Leave your job and: • Have at least eight years of service but less than 10…	You may continue coverage by: • Submitting appropriate form(s) within 60 days of when coverage would end; • Pay the full cost of coverage; and • Provide a statement from your employer verifying your service.
Leave your job and: • Have at least 10 years of service but before minimum age to qualify for an immediate retirement annuity; and • You leave money in the retirement system.	You may continue coverage by: • Submitting appropriate form(s) within 60 days of when coverage would end; • Pay the full cost of coverage until your annuity begins; and • Pay lower Member premiums once the annuity begins.
The chart above applies for most SHBP Members; certain parts of the Georgia code may stipulate other conditions for SHBP continuation.	

Member contributions not remitted to the Plan by the due date may result in suspension/and or termination of coverage.

When Coverage May Be Continued For Your Dependents

Coverage for your dependents will end at the same time you lose coverage because you are no longer eligible. Here are other situations that can affect coverage for you and your dependents.

Situation	Effect on coverage
If enrolled dependent is a stepchild under age 19 and does not meet the 180-day residency requirement.	Coverage ends at the end of the month in which dependent no longer meets the 180 day residency requirement.
If enrolled dependent is a full-time Student at an accredited college, university or other institution. NOTE: **For Retired Members**: Failure to submit full-time student verification before coverage ends at age 19 and each subsequent year will result in loss of eligibility for dependent, unless they re-enroll within 31 days of a qualifying event. **For Active Members**: Verification documentation must be submitted timely for a student to be covered under the Plan. Once verification documentation is received, coverage will be verified to the qualifying event date or 1st day of the coverage plan year, whichever is later.	Coverage ends on the last day of the month in which the earliest of these qualifying events occurs: • Graduation or completion of requirements if graduation is delayed. • Full-time attendance ends – unless child has attended previous two consecutive semesters and plans to return after a one semester break. • Dependent reaches age 26. • Dependent marries. • Dependent becomes employed in a benefits-eligible position.
If you divorce, your spouse loses coverage as your dependent*	Coverage ends at the end of the month in which the divorce becomes final.
If you or your spouse or eligible dependent(s) lose(s) other group health insurance coverage because of change in employment	Before you lose coverage or within 31 days after losing coverage, file request for SHBP coverage, which will start on the first day of the month following the request.
If you declined coverage for yourself or your dependents because of other group health insurance coverage, and you later lose that coverage	You may enroll yourself and dependents if you request this coverage within 31 days of the qualifying event. Coverage will be effective on the first day of the month following the request.

If you receive a court order to provide health coverage for a divorced spouse, you may temporarily continue Plan coverage for the divorced spouse by electing COBRA continuation coverage, which is limited to 36 months of coverage. You must request a COBRA information packet from the SHBP within 60 days of the qualifying event.

A general note regarding documentation sent to the Plan: SHBP requires that coverage requests are made within a specific time period and requires documentation to support the request. When SHBP requests documentation, if the documentation is not received within 31days of the SHBP request, the effective date of the coverage change will be the later of the qualifying event date or first day of the plan year, whichever is later.

How to Request a Change

During Open Enrollment and the Retiree Option Change Period, Members can go online to make coverage changes for the upcoming Plan year. See the current *Health Plan Decision Guides* for Web addresses and instructions. If you do not have Internet access or if your request is in the middle of a Plan year, then:

- **An active Employees should notify his/her personnel/payroll office to obtain the appropriate form. If you miss the deadline, you won't be able to make your change until the next Open Enrollment or unless a qualifying event occurs. .**
- **A retired Member should contact the SHBP eligibility unit directly. You must complete and return the form by the appropriate deadline. If you miss the deadline, changes will not be permitted.**

Provisions for Eligible Retirees & Considerations for Members Near Retirement

Plan Membership

This section includes Plan Membership and coordination of benefits information for eligible retirees as well as important points to consider if you are near retirement. SHBP will pay primary benefits for non-enrolled Medicare retirees but a higher premium will be charged for primary benefits.

Eligibility

You may be able to continue Plan coverage if you are enrolled in the Plan when you retire and are immediately eligible to draw a retirement annuity from any of these systems:

- Employees' Retirement System (ERS).
- Teachers Retirement System (TRS).
- Public School Employees Retirement System (PSERS).
- Local School System Teachers Retirement Systems.
- Fulton County Retirement System (eligible Members).
- Legislative Retirement System.
- Superior Court Judges or District Attorney's Retirement System.

Important Note: Individuals who have withdrawn money from their respective retirement system will not be able to continue health coverage as a retiree. Eligibility for temporary extended coverage under COBRA provisions would apply.

Applying for Coverage Continuation

If you are an eligible retiree, you must apply for continued coverage for yourself and Covered Dependents within 60 days of the date your active coverage ends. Application can be made on a *Retirement/Surviving Spouse Form,* available through your personnel/payroll office or by contacting SHBP's Eligibility Unit. Members of ERS, TRS, and PSERS will be automatically enrolled in the same active coverage and sent a letter advising them the change was made and allowing them to make changes to their option within 31 days of the date of the letter. **Failure to apply timely or make the appropriate premium payments terminates your eligibility for retiree coverage.**

When Coverage Begins For You

If you are eligible for a monthly annuity at the time you retire, your coverage starts immediately at retirement, provided that you make proper premium payments or have them deducted from your annuity check. Coverage for your dependents (if you elect to continue dependent coverage) starts on the same day that your retiree coverage begins. A change from single to family coverage as a retiree is allowed only if you make the request within 31 days of the qualifying event. Due to new Centers for Medicare & Medicaid Services (CMS) regulations, the spouse's social security number is required.

When Coverage Ends For You

Coverage will end when you discontinue coverage or fail to pay premiums on time.

When Coverage Ends For Your Dependents

Coverage for your dependents will end when:

- They are no longer eligible.
- You fail to document eligibility.
- You change from family to single coverage.
- You do not pay premiums on time.
- Your coverage as a Member ends.

Keep in mind that if dependents are dropped from your coverage, you will *not* be able to enroll them again – unless you have a qualifying event.

Continuing Dependent Coverage at Your Death

In the event of your death, your covered surviving spouse or eligible dependents should contact the applicable retirement system (ERS, TRS, PSERS, etc.) and the Plan as soon as possible, but no later than 31 days from the date of your death. To continue coverage, surviving spouses or eligible children must complete a Retirement/Surviving Spouse Form and send it to the Plan within 31 days of your death.

Plan provisions vary for survivors:

Surviving spouse receives annuity

- Plan coverage may continue after your death.
- Premiums will be deducted from annuity.
- Spouse sends payments directly to Plan if annuity is not large enough to cover premium.
- New dependents or spouses *cannot* be added to survivor's coverage.
- A surviving spouse who becomes eligible for coverage as an active employee must discontinue the surviving spouse coverage and enroll as an active employee.
- When your active SHBP coverage terminates, surviving spouse coverage may be reinstated. You will be eligible for continuous coverage, based on the conditions that first made you eligible as a surviving spouse.

Surviving spouse does not receive annuity

- Plan coverage may continue after your death if spouse was married to you at least one year before death.
- Spouse sends payments directly to the Plan.
- Coverage ends if the surviving spouse remarries.

Surviving child does not receive annuity and there is no surviving spouse.

- Plan coverage may continue under COBRA provisions.

Making Changes to Your Retiree Coverage

You can make changes to your coverage tier only at these times:

- Within 31 days of a qualifying event.
- During the annual Retiree Option Change Period.
  - You may change your Plan option only.
  - Adding dependents is not permitted unless you have a qualifying event as described in the section below.

Note: Upon retirement, your coverage will be changed to single or family, based on your covered dependents.

Qualifying Events

If you have this qualifying event…	You may…
• Within 31 days of eligibility for retiree coverage • Annuity no longer covers premium amount • Become eligible for Medicare	Change to an available option
You retire and immediately qualify for a retirement annuity You must complete and submit Plan enrollment form no later than 60 days after leaving active employment	• Change your coverage tier to single at any time; or • Change your plan option. Note: If you have employee + spouse, employee + child(ren), employee +child(ren) + spouse, you will be changed to family tier.
You, your spouse, or all enrolled dependents become eligible for Medicare or Medicaid Required to submit proof of enrollment in Part A, B, and D to reduce premiums	• Discontinue your coverage. If you are retired and discontinue your SHBP coverage when you enroll for Medicare, you will not be able to enroll again for SHBP coverage • Retirees may change to any available option upon becoming eligible for Medicare coverage.
• Within 31 days of acquiring a dependent because of marriage, birth, adoption or Qualified Medical Child Support Order (QMCSO) • Within 31 days of non-voluntary loss of a dependent's health benefit coverage through spouse's or Medicaid*, Medicare, group coverage through employment, retirement or COBRA coverage Note: Discontinuation because of an increase in premium is not a qualifying event. * Note: Effective April 1, 2009, for Medicaid only, the 31 days changes to 60 days for listed actions.	Add your eligible dependent(s) Proper documentation is required **Surviving spouses and dependents cannot change from single to family coverage*
• Within 31 days of a spouse or enrolled dependent's employment status changes, affecting coverage eligibility under a qualified health plan	Change coverage tier within 31 days of the qualifying event; proper documentation is required
You and spouse are both retirees who both have sufficient retirement benefits from a covered retirement system to have Plan premiums deducted. New dependents or spouses *cannot* be added to survivor's coverage.	Change at any time from family coverage to each having single coverage; a request to change from family to single for you and the request for single coverage for your spouse must be filed at the same time.

You must request a coverage change within 31 days of the qualifying event by:

- Contacting the Plan directly; and
- Returning the necessary form(s) with any requested documentation to the Plan by the deadline. ***** Fill out the form(s) completely.

If you miss the deadline, you will not have another chance to make the desired change. If the deadline is met, your change will take effect on the first day of the month following the receipt of your request, unless indicated above.

*** Do not hold form requesting change even if you are waiting on documentation. Request must be made within 31 days of qualifying event.**

Changes Permitted Without A Qualifying Event

If you have this non-qualifying event…	You may…
• Within 31 days of eligibility for retiree coverage • Annuity no longer covers premium amount • Become eligible for Medicare	Change to an available option

Retirees may change from family to single coverage, or discontinue coverage at anytime by submitting the appropriate Plan form. However, if you change from family to single coverage, you cannot increase your coverage later without a qualifying event. Also, if you discontinued coverage, you may not enroll later unless you return to work in a State of Georgia benefit eligible position.

Important Note On Coverage Changes: If your current Plan option is not offered in the upcoming Plan year and you do not elect a different option available to you during the Retiree Option Change Period, your coverage will be transferred automatically to an Option selected by the SHBP effective January 1st of the subsequent Plan year.

Retiree Option Change Period

During the 30-day Retiree Option Change Period – generally from mid-October to mid-November each Plan year – you can make these changes to your coverage:

- Select a new coverage option;
- Change from family to single coverage; or
- Discontinue coverage (Note that re-enrollments are not allowed).

Changes will take effect the following January 1st.

Before the Retiree Option Change Period begins, the Plan will send you a retiree information packet. The packet will include:

- Information on the Plan options;
- Steps for notifying the Plan about coverage selections for the new Plan year;
- Forms you may need to complete; and
- Informational resources.

To ensure that you receive the information packet, make sure the Plan always has your most up-to-date mailing address. If you do not receive your ROCP packet by mid-October, you should contact the SHBP Eligibility Unit.

If You Return to Active Service

If you choose to return to active service with an employing entity under the Plan, whether immediately after you retire or at a later date, your retirement annuity may be suspended or continued. Health Plan coverage, however, must be purchased as an active employee through payroll deductions. You will need to complete enrollment paperwork with your Employer.

When you return to retired status, retiree coverage may be reinstated after notifying the Plan within 31 days. You will be eligible for continuous coverage, based on the conditions that first made you eligible as a retiree.

If you retired before the initial legislative funding for a particular employee group, you will not be entitled to retiree Plan coverage – unless the final service period qualifies you for a retirement benefit from a state-supported retirement system.

Special Note: Re-enrollment into retiree coverage is not automatic. You must request coverage within 31 days of loss of active coverage or you will lose eligibility for retiree coverage.

Impact of Medicare on Benefits/Premiums

Coordination of Benefits With Medicare

Medicare is the country's health insurance program for people age 65 or older who qualify based on Medicare eligibility rules. Medicare also covers certain people with disabilities who are under age 65 and people of any age who have permanent kidney failure.

To prevent duplicate benefit payment, the Plan coordinates benefits with Medicare and any other plan that may cover you and your dependents. The first step in coordination is the determination of which plan is primary – or which plan pays benefits first - and which plan is secondary. Under Georgia law, the SHBP is required to subordinate health benefits to Medicare benefits.

The chart below provides important details related to primary and secondary coverage based on your Medicare status:

If you are retired and …	**The Plan will pay…**
…age 65, Medicare-eligible and enrolled in Part A, Part B, and Part D; consider enrolling prior to the month in which you turn 65 to pay a lower SHBP premium	Secondary benefits starting on the first day of the month in which you turn 65
…age 65, Medicare-eligible and do *not* enroll in Part A, Part B and Part D	Primary benefits; however, Plan premium will increase
…age 65 or older and not enrolled in Medicare	Primary benefits; however, Plan premium will increase
. . age 65 or older and not enrolled in Medicare Part A, but enrolled in Medicare Part B and/or D	Primary benefits for Part A and secondary benefits for Part B and D

State Health Benefit Plan (SHBP) Medicare Policy

- Georgia law requires that SHBP pay benefits after Medicare has paid.
- SHBP will calculate premiums and claims payments based upon Medicare enrollment for retirees at age 65 or older or those eligible for Medicare due to a disability.
- Premiums will be based on the Parts of Medicare (A, B and D) that you have. There will be no adjustments in premiums because you have other coverage such as TRICARE, VA or other group coverage since SHBP may have potential primary liability.
- SHBP will coordinate benefits for Members who are enrolled in Medicare A, B or D.
- SHBP will pay primary benefits on Members not enrolled in Medicare, but you will pay a higher premium.
- If you enroll in Medicare (A, B or D), please send a copy of your Medicare cards by one month prior to the effective date in which you are eligible for Medicare. Premiums cannot be reduced until copies of your Medicare cards are received and the change in premium is processed by the retirement system. Delay in submission of Medicare information does not qualify for a refund of the difference in premiums.

Medicare information is available at:

- www.cms.hhs.gov/medicarereform
- www.medicare.gov
- www.ssa.gov
- 1-800-669-8387 (Georgia Cares)
- 1-800-633-4227 (Medicare)

Federal Other General Legal Requirements

The following pages explain your rights and responsibilities under federal laws and regulations. Some states may have similar requirements. If a similar provision appears elsewhere in this booklet, the provision which provides the better benefit will apply.

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Plan Document

This Summary Plan Description presents an overview of your benefits. If there are discrepancies between the information in this SPD and DCH Board regulations or the laws of the state of Georgia, those regulations and laws will govern at all times.

Relationship with Providers

The relationships between SHBP, CIGNA Healthcare, and Network providers are solely contractual relationships between independent contractors. Network providers are not our agents or employees, nor are they agents or employees of CIGNA Healthcare. Neither CIGNA Healthcare nor any of our employees are agents or employees of Network providers.

CIGNA Healthcare does not provide health care services or supplies, nor does CIGNA Healthcare practice medicine. Instead, CIGNA Healthcare pays benefits for Covered Services. Network providers are independent practitioners who run their own offices and facilities. The credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. Network providers are not the employees of SHBP or CIGNA Healthcare, nor does either have any other relationship with Network providers such as principal-agent or joint venture. Neither we nor CIGNA Healthcare are liable for any act or omission of any provider. CIGNA Healthcare is not considered to be an employer of the SHBP for any purpose with respect to the administration or provision of benefits under this Plan. We and CIGNA Healthcare are solely responsible for all of the following:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of benefits.
- Notifying you of the termination or modifications to the Plan.

Your Relationship with Providers

The relationship between you and any provider is that of provider and patient.

- You are responsible for choosing your own provider.
- You must decide if any provider treating you is right for you. This includes Network providers you choose and providers to whom you have been referred.
- You must decide with your provider what care you should receive.
- Your provider is solely responsible for the quality of the services provided to you.

Incentives to You

Sometimes CIGNA Healthcare may offer incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but we recommend that you discuss participating in such programs with your Physician. These incentives are not benefits and do not alter or affect your benefits. Contact CIGNA Healthcare if you have any questions.

Interpretation of Benefits

SHBP and CIGNA Healthcare have sole and exclusive discretion to do all of the following:

- Interpret benefits under the Plan.
- Interpret the other terms, conditions, limitations and exclusions of the Plan, including this SPD and any Riders and Amendments.
- Make factual determinations related to the Plan and its benefits. SHBP and CIGNA Healthcare may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the Plan.

Administrative Services

We may, in our sole discretion, arrange for various persons or entities to provide administrative services in regard to the Plan, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time in our sole discretion. We are not required to give you prior notice of any such change, nor are we required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

Clerical Error

If a clerical error or other mistake occurs, that error does not create a right to benefits. These errors include, but are not limited to, providing misinformation on eligibility or benefit coverages or entitlements. It is your responsibility to confirm the accuracy of statements made by us or our designees, including CIGNA Healthcare, in accordance with the terms of this SPD and other Plan documents.

Information and Records

At times we or CIGNA Healthcare may need additional information from you. You agree to furnish us and/or CIGNA Healthcare with all information and proofs that we may reasonably require regarding any matters pertaining to the Plan. If you do not provide this information when we request it, we may delay or deny payment of your benefits.

By accepting benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish us or CIGNA Healthcare with all information or copies of records relating to the services provided to you. We or CIGNA Healthcare have the right to request this information at any reasonable time.

This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Member's enrollment form. We and CIGNA Healthcare agree that such information and records will be considered confidential.

We and CIGNA Healthcare have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as we are required to do by law or regulation. During and after the term of the Plan, we, CIGNA Healthcare, and our related entities may use and transfer the information gathered under the Plan for research and analytic purposes.

For complete listings of your medical records or billing statements we recommend that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from us, we also may charge you reasonable fees to cover costs for completing the forms or providing the records. In some cases, we or CIGNA Healthcare will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Such designees have the same rights to this information as SHBP.

Examination of Covered Persons

In the event of a question or dispute regarding your right to benefits, we may require that a Network Physician of our choice examine you at our expense.

Workers' Compensation not Affected

Benefits provided under the Plan do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

Your Rights for Continuing Group Health Plan Coverage

You have the right to continue group health plan coverage if you lose Plan coverage due to a qualifying event. In this case, you may continue health care coverage for yourself, spouse or dependents; however, you or your dependents may have to pay for such coverage. Review this Summary Plan Description (SPD) and other Plan documents governing your COBRA continuation coverage rights.

Your Responsibilities as an Employee Enrolled in Plan Coverage

As an employee enrolled in Plan coverage, you can receive the most value from your coverage if you fulfill the following responsibilities:

- **Make proper and timely premium payments.** Premium payments usually are made through convenient payroll deduction. It's your responsibility to make sure that your employer (the State, school district, agency, etc.) is deducting the right amount from your paycheck for your option and coverage tier. When you are first hired, and later during each Open Enrollment (or Retiree Option Change Period), you will receive premium information. If you are mailing premiums to the Plan – when you are on leave without pay, for example – your payments must be received on time at the Plan.
- **Make accurate choices when you make your enrollment selection.** After the Open Enrollment period ends, the Plan will make changes only when there is a documented administrative error. Any premium refund will be limited to 12 months of premiums and is payable only after the Plan receives documented evidence from the Member that the Plan had no liability for additional Covered Persons.
- **Take the time to understand how the Plan option works.** You are the manager of your health care needs and, therefore, you must take the time to understand your Plan option. You also are responsible for understanding the consequences of your decisions. Carefully review this booklet and the *Health Plan Decision Guide.* Having read the documents, you can take steps to maximize your coverage.
- **Know when and how your participation can end.** Generally, coverage ends when you no longer meet job classification or working-hours requirements for eligibility or when you fail to make the proper premium payments. For eligibility requirements and other circumstances that may result in loss of coverage, see the sections titled **Eligibility-Effective Date**.
- **Notify, in writing, SHBP Eligibility Unit and your payroll office of any address changes.**
- **Notify the Plan if you have a qualifying event that can affect coverage or eligibility for coverage for you or a Covered Dependent.** If you get married, divorced or have a baby, you may want to add or delete a dependent. You must notify your payroll location within 31 days of the qualifying event – or you won't be able to make the change until the next Open Enrollment period. Retirees do not have an Open Enrollment period; failure to notify the Plan within 31 days of a qualified change in status could permanently prohibit a retiree from making the desired change.
- **Furnish the Plan with information required to implement Plan provisions**. You are required to provide any information and documentation that the Plan needs to carry out its provisions. If you do not provide the information within 31 days, your request for benefits or Plan Membership will be denied. If the Plan pays benefits for a dependent who is subsequently found ineligible for coverage, or you are not able to document dependent eligibility when requested by the Plan, the Plan has the right to:
  - Recover any and all payments made by the Plan on behalf of the ineligible dependent, and
  - Terminate the dependent's coverage retroactively to his or her coverage effective date without prejudicing any other rights or remedies available to the Plan under law.
- **Update the Plan on the status of eligible dependents.** If your dependent child is nearing age 19, you are responsible for informing the Plan of his or her status within 31 days. Coverage won't continue automatically after an eligible dependent turns 19 – you must request it. You also must notify the Plan when a dependent gets married, enters the military or, when the dependent is 19 or older, graduates or stops attending school full-time.

- **Notify the Plan of any other group coverage you have,** including Medicare coverage. You may be required to provide notification in advance or on request.

Your Employer's Responsibilities

Your employer – your department, agency or other entity – has specific responsibilities under the Plan, which includes the following:

- Submit any necessary documentation in a timely and efficient manner.
- Withhold proper monthly premiums and submit them, along with the bill, to the Plan when due. If your employer does not send in premiums and documentation in a proper and timely manner, the Plan may suspend coverage benefit payments for the Employee.
- Assist in enrolling all eligible full-time employees in the Plan within 31 days of hire.
- Provide enrollment information to the Plan Administrator.
- Distribute Plan materials, including this SPD booklet, and hold group meetings to give you information about the Plan at the Plan Administrator's request.
- Administer the Family and Medical Leave Act (FMLA) in compliance with federal law.
- Provide you with information on how you can continue coverage under the FMLA and under state leave-without-pay provisions.
- Provide necessary termination of coverage information to the Plan Administrator within 30 days after your employment ends or your eligibility for Plan Membership ends.
- Notify enrolled employees of Plan amendments or termination.

Assistance With Your Questions

If you have any questions about your rights and responsibilities under this Plan, you should contact the Plan's Eligibility Unit at 404-656-6322 in Atlanta, or at 800-610-1863 outside of Atlanta.

Notice of Provider Directory/Networks

Notice Regarding Provider/Pharmacy Directories and Provider/Pharmacy Networks

You may access a list of Providers who participate in the network by visiting myCIGNA.com or by calling the toll-free telephone number on your ID card.

Your Participating Provider/Pharmacy networks consist of a group of local medical practitioners, and Hospitals, of varied specialties as well as general practice or a group of local Pharmacies who are contracted with CIGNA HealthCare.

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Legal Notices

Department of Community Health Privacy Notice

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Plan's Privacy Commitment to You

The Georgia Department of Community Health (DCH) understands that information about you and your family is personal. DCH is committed to protecting your information. This notice tells you how DCH uses and discloses information about you. It tells you your rights and the Plan's requirements about your information.

Understanding the Type of Information That the Plan Has

Your employer (state agency, school system, authority, etc.) sent information about you to DCH. This information included your name, address, birth date, phone number, Social Security Number and other health insurance policies that you may have. It may also have included health information. When your health care Providers send claims to CIGNA Healthcare for payment, the claims include your diagnoses and the medical treatments you received. For some medical treatments, your health care Providers send additional medical information to the Plan such as doctor's statements, x-rays or lab test results.

Your Health Information Rights

- You have the following rights regarding the health information that DCH has about you.
- You have the right to see and obtain a copy of your health information. An exception is psychotherapy notes. Another exception is information that is needed for a legal action relating to DCH.
- You have the right to ask DCH to change health information that is incorrect or incomplete. DCH may deny your request under certain circumstances.
- You have the right to request a list of the disclosures that DCH has made of your health information beginning in April 2003.
- You have the right to request a restriction on certain uses or disclosures of your health information. DCH is not required to agree with your request.
- You have the right to request that DCH communicates with you about your health in a way or at a location that will help you keep your information confidential.
- You have the right to receive a paper copy of this notice. You may ask DCH staff to give you another copy of this notice, or you may obtain a copy from DCH's Web site, www.dch.georgia.gov (click on "Privacy").

Privacy Law's Requirements

DCH is required by law to:

- Maintain the privacy of your information.
- Give you this notice of DCH's legal duties and privacy practices regarding the information that DCH has about you.
- Follow the terms of this notice.
- Not use or disclose any information about you without your written permission, except for the reasons given in this notice. You may take away your permission at any time, in writing, except for the information that DCH disclosed before you stopped your permission. If you cannot give your permission due to an emergency, DCH may release the information if it is in your best interest. DCH must notify you as soon as possible after releasing the information.

In the future, DCH may change its privacy practices. If its privacy practices change significantly, DCH will provide a new notice to you. DCH will post the new notice on its Web site at www.dch.georgia.gov (click on "Privacy"). This notice is effective April 14, 2003.

How DCH Uses and Discloses Health Care Information

There are some services the Plan provides through contracts with private companies. For example, CIGNA Healthcare pays most medical claims to your health care providers. When services are contracted, the Plan may disclose some or all of your information to the company so that they can perform the job the Plan has asked them to do. To protect your information, the Plan requires the company to safeguard your information in accordance with the law.

The following categories describe different ways that the Plan uses and discloses your health information. For each category, we will explain what we mean and give an example.

For Payment: The Plan may use and disclose information about you so that it can authorize payment for the health services that you received. For example, when you receive a service covered by the Plan, your health care provider sends a claim for payment to CIGNA Healthcare.

The claim includes information that identifies you, as well as your diagnoses and treatments.

For Medical Treatment: The Plan may use or disclose information about you to ensure that you receive necessary medical treatment and services.

To Operate Various Plan Programs: The Plan may use or disclose information about you to run various Plan programs and ensure that you receive quality care. For example, the Plan may contract with a company that reviews Hospital records to check on the quality of care that you received and the outcome of your care.

To Other Government Agencies Providing Benefits or Services:

The Plan may give information about you to other government agencies that are giving you benefits or services. The information must be necessary for you to receive those benefits or services.

To Keep You Informed: The Plan may mail you information about your health and well-being. Examples are information about managing a disease that you have, information about your managed care choices, and information about Prescription Drugs you are taking.

For Overseeing Health Care Providers: The Plan may disclose information about you to the government agencies that license and inspect medical facilities, such as Hospitals, as required by law.

For Research: The Plan may disclose information about you for a research project that has been approved by a review board. The review board must review the research project and its rules to ensure the privacy of your information. The research must be for the purpose of helping the Plan.

As Required by Law: The Plan will disclose information about you as required by law.

For More Information and to Report a Problem

If you have questions and would like additional information, you may contact the SHBP at 404-656-6322 (Atlanta calling area) or 800-610-1863 (outside of Atlanta calling area). If you believe your privacy rights have been violated:

- You can file a complaint with the Plan by calling the SHBP at 404-656-6322 (Atlanta calling area) or 800-610-1863 (outside of Atlanta calling area), or by writing to: SHBP – HPU, P.O. Box 1990, Atlanta, GA 30301-1990.
- You can file a complaint with the Health and Human Services Office for Civil Rights, Region IV, Atlanta Federal Center, 61 Forsyth Street SW, Suite 3B70, Atlanta, GA 30303-8909. Phone 404-562-7886; Fax 404-562-7884.
- You may also contact the HHS Office for Civil Rights by calling 1-866-OCR-PRIV 1-866-627-7748 or e-mail to OCR at OCRComplaint@hhs.gov.

There will be no retaliation for filing a complaint or grievance.

Qualified Medical Child Support Order (QMCSO)

Eligibility for Coverage Under a QMCSO

If a Qualified Medical Child Support Order (QMCSO) is issued for your child, that child will be eligible for coverage as required by the order and you will not be considered a Late Entrant for Dependent Insurance.

You must notify your Employer and elect coverage for that child and yourself, if you are not already enrolled, within 31 days of the QMCSO being issued.

Qualified Medical Child Support Order Defined

A Qualified Medical Child Support Order is a judgment, decree or order (including approval of a settlement agreement) or administrative notice, which is issued pursuant to a state domestic relations law (including a community property law), or to an administrative process, which provides for child support or provides for health benefit coverage to such child and relates to benefits under the group health plan, and satisfies all of the following:

1. the order recognizes or creates a child's right to receive group health benefits for which a participant or beneficiary is eligible;
2. the order specifies your name and last known address, and the child's name and last known address, except that the name and address of an official of a state or political subdivision may be substituted for the child's mailing address;
3. the order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;
4. the order states the period to which it applies; and
5. if the order is a National Medical Support Notice completed in accordance with the Child Support Performance and Incentive Act of 1998, such Notice meets the requirements above.

The QMCSO may not require the health insurance policy to provide coverage for any type or form of benefit or option not otherwise provided under the policy, except that an order may require a plan to comply with State laws regarding health care coverage.

Payment of Benefits

Any payment of benefits in reimbursement for Covered Expenses paid by the child, or the child's custodial parent or legal guardian, shall be made to the child, the child's custodial parent or legal guardian, or a state official whose name and address have been substituted for the name and address of the child.

FDRL2 V1

Special Enrollment Rights Under the Health Insurance Portability & Accountability Act (HIPAA)

If you or your eligible Dependent(s) experience a special enrollment qualifying event as described below, you or your eligible Dependent(s) may be entitled to enroll in the Plan outside of a designated enrollment period upon the occurrence of one of the special enrollment qualifying events listed below. If you are already enrolled in the Plan, you may request enrollment for you and your eligible Dependent(s) under a different option offered by the Employer for which you are currently eligible. If you are not already enrolled in the Plan, you must request special enrollment for yourself in addition to your eligible Dependent(s). You and all of your eligible Dependent(s) must be covered under the same option. The special enrollment qualifying events include:

- **Acquiring a new Dependent.** If you acquire a new Dependent(s) through marriage, birth, adoption or placement for adoption, you may request special enrollment to enroll and/or change your coverage tier to add eligible dependents.
- **Loss of eligibility for other coverage (excluding continuation coverage).** If eligibility under another group plan was lost, you and all of your eligible Dependent(s) may request special enrollment in this Plan. If required by the Plan, when enrollment in this Plan was previously declined, it must have been declined in writing with a statement that the reason for declining enrollment was due to other health coverage. This provision applies to loss of eligibility as a result of any of the following:

- divorce or legal separation;
- cessation of Dependent status (such as reaching the limiting age);
- death of the Employee;
- termination of employment;
- reduction in work hours to below the minimum required for eligibility;
- you or your Dependent(s) no longer reside, live or work in the other plan's network service area and no other coverage is available under the other plan;
- you or your Dependent(s) incur a claim which meets or exceeds the lifetime maximum limit that is applicable to all benefits offered under the other plan; or
- the other plan no longer offers any benefits to a class of similarly situated individuals.
    - **Termination of employer contributions (excluding continuation coverage).** If a current or former employer ceases all contributions toward the Employee's or Dependent's other coverage, special enrollment may be requested in this Plan for you and all of your eligible Dependent(s).
    - **Exhaustion of COBRA or other continuation coverage.** Special enrollment may be requested in this Plan for you and all of your eligible Dependent(s) upon exhaustion of COBRA or other continuation coverage. If you or your Dependent(s) elect COBRA or other continuation coverage following loss of coverage under another plan, the COBRA or other continuation coverage must be exhausted before any special enrollment rights exist under this Plan. An individual is considered to have exhausted COBRA or other continuation coverage only if such coverage ceases: (a) due to failure of the employer or other responsible entity to remit premiums on a timely basis; (b) when the person no longer resides or works in the other plan's service area and there is no other COBRA or continuation coverage available under the plan; or (c) when the individual incurs a claim that would meet or exceed a lifetime maximum limit on all benefits and there is no other COBRA or other continuation coverage available to the individual. This does not include termination of an employer's limited period of contributions toward COBRA or other continuation coverage as provided under any severance or other agreement.

FDRL3 V3

Special enrollment must be requested within 30 days after the occurrence of the special enrollment qualifying event. If the special enrollment qualifying event is the birth or adoption of a Dependent child, coverage will be effective immediately on the date of birth, adoption or placement for adoption. Coverage with regard to any other special enrollment qualifying event will be effective on the first day of the calendar month following receipt of the request for special enrollment.

Individuals who enroll in the Plan due to a special enrollment qualifying event will not be considered Late Entrants. Any Pre-existing Condition limitation will be applied upon enrollment, reduced by prior Creditable Coverage, but will not be extended as for a Late Entrant.

Domestic Partners and their children (if not legal children of the Employee) are not eligible for special enrollment.

FDRL4 V2

Effect of Section 125 Regulations on This Plan

Your Employer has chosen to administer this Plan in accordance with Section 125 Regulations of the Internal Revenue Code. Per this regulation, you may agree to a pretax salary reduction put toward the cost of your benefits. Otherwise you will receive your taxable earnings as cash (salary).

Provisions in this certificate which allow for enrollment or coverage changes not consistent with Section 125 Regulations are superseded by this section.

Coverage Elections

Per Section 125 Regulations, you are generally allowed to enroll for or change coverage only before each annual benefit period. However, exceptions are allowed if you enroll for or change coverage within 30 days of the following:

- the date you meet Special Enrollment criteria per federal requirements as described in the Section entitled “Eligibility – Effective Date/Exception to Late Entrant Definition”; or
- the date you meet criteria shown in the section entitled “Change of Status.”

GM 6000 SCT125V1

Eligibility for Coverage for Adopted Children

Any child under the age of 18 who is adopted by you, including a child who is placed with you for adoption, will be eligible for Dependent Insurance upon the date of placement with you. A child will be considered placed for adoption when you become legally obligated to support that child, totally or partially, prior to that child’s adoption.

If a child placed for adoption is not adopted, all health coverage ceases when the placement ends, and will not be continued.

The provisions in the “Exception for Newborns” section of this document that describe requirements for enrollment and effective date of insurance will also apply to an adopted child or a child placed with you for adoption.

FDRL6

Federal Tax Implications for Dependent Coverage

Premium payments for Dependent health insurance are usually exempt from federal income tax. Generally, if you can claim an individual as a Dependent for purposes of federal income tax, then the premium for that Dependent’s health insurance coverage will not be taxable to you as income. However, in the rare instance that you cover an individual under your health insurance who does not meet the federal definition of a Dependent, the premium may be taxable to you as income. If you have questions concerning your specific situation, you should consult your own tax consultant or attorney.

FDRL7

Coverage for Maternity Hospital Stay

Group health plans and health insurance issuers offering group health insurance coverage generally may not, under a federal law known as the “Newborns’ and Mothers’ Health Protection Act”: restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section; or require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of the above periods. The law generally does not prohibit an attending provider of the mother or newborn, in consultation with the mother, from discharging the mother or newborn earlier than 48 or 96 hours, as applicable.

Please review this Plan for further details on the specific coverage available to you and your Dependents.

FDRL8

Women’s Health and Cancer Rights Act (WHCRA)

Do you know that your plan, as required by the Women’s Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call Member Services at the toll free number listed on your ID card for more information.

FDRL51

Certificate of Prior Creditable Coverage

You must provide proof of your prior Creditable Coverage in order to reduce a Pre-Existing Condition limitation period. You should submit proof of prior coverage with your enrollment material. A certificate of prior Creditable Coverage, or other proofs of coverage which need to be submitted outside the standard enrollment form process for any reason, may be sent directly to: Eligibility Services, CIGNA HealthCare, P.O.Box 9077, Melville, NY 11747-9077. You should contact the Plan Administrator or a CIGNA Customer Service Representative if assistance is needed to obtain proof of prior Creditable Coverage. Once your prior coverage records are reviewed and credit is calculated, you will receive a notice of any remaining Pre-existing Condition limitation period.

Creditable Coverage

Creditable Coverage will include coverage under any of the following: A self-insured employer group health plan; Individual or group health insurance indemnity or HMO plans; Part A or Part B of Medicare; Medicaid, except coverage solely for pediatric vaccines; A health plan for certain Members of the uniformed armed services and their dependents, including the Commissioned Corps of the National Oceanic and Atmospheric Administration and of the Public Health Service; A medical care program of the Indian Health Service or of a tribal organization; A state health benefits risk pool; The Federal Employees Health Benefits Program; A public health plan established by a State, the U.S. government, or a foreign country; the Peace Corps Act; Or a State Children's Health Insurance Program.

Obtaining a Certificate of Creditable Coverage Under This Plan

Upon loss of coverage under this Plan, a Certificate of Creditable Coverage will be mailed to each terminating individual at the last address on file. You or your dependent may also request a Certificate of Creditable Coverage, without charge, at any time while enrolled in the Plan and for 24 months following termination of coverage. You may need this document as evidence of your prior coverage to reduce any pre-existing condition limitation period under another plan, to help you get special enrollment in another plan, or to obtain certain types of individual health coverage even if you have health problems. To obtain a Certificate of Creditable Coverage, contact the SHBP Eligibility Unit.

FDRL12

Requirements of Family and Medical Leave Act of 1993

Any provisions of the policy that provide for: (a) continuation of insurance during a leave of absence; and (b) reinstatement of insurance following a return to Active Service; are modified by the following provisions of the federal Family and Medical Leave Act of 1993, where applicable:

A. Continuation of Health Insurance During Leave

Your health insurance will be continued during a leave of absence if:

- that leave qualifies as a leave of absence under the Family and Medical Leave Act of 1993; and
- you are an eligible Employee under the terms of that Act.

The cost of your health insurance during such leave must be paid, whether entirely by your Employer or in part by you and your Employer.

B. Reinstatement of Canceled Insurance Following Leave

Upon your return to Active Service following a leave of absence that qualifies under the Family and Medical Leave Act of 1993, any canceled insurance (health, life or disability) will be reinstated as of the date of your return.

You will not be required to satisfy any eligibility or benefit waiting period or the requirements of any Pre-existing Condition Limitation to the extent that they had been satisfied prior to the start of such leave of absence.

Your Employer will give you detailed information about the Family and Medical Leave Act of 1993.

GM6000 TRM191V1

Continuing Coverage Under Family and Medical leave Act (FMLA)

You may continue medical coverage for yourself and your dependents for up to 12 weeks for specific medical and/or family medical reasons. Forms for continuing your coverage are available from your personnel/payroll office.

During FMLA leave without pay, the SHBP will bill you directly for coverage premiums. How FMLA affects your coverage depends on the circumstances involving your leave.

If you have this situation…	The impact is this…
• Choose not to continue coverage while on leave	• Claims will not be paid by SHBP for the period after coverage terminates and while you remain on leave. You are responsible for paying Providers. • You must resume coverage when you return to work.
• Open Enrollment period occurs while on leave	• If you continue coverage while on leave, you may change coverage as permitted during Open Enrollment. • If you do not continue coverage while on leave, contact your employer for Open Enrollment information.
• Do not return to work after your leave ends and you have paid your premiums directly to the Plan during your leave.	• You may be eligible to continue your medical coverage through COBRA.

Continuing Coverage During Military Leave

You and your dependents have the right to continue your coverage for up to 18 months with premium payments sent directly to the SHBP.

- If you are an activated military reservist called on an emergency basis, you will pay your employee share of the premium.
- For other military leaves, you will be required to pay the full premium. Also, you will be charged a monthly processing fee.

You may elect to discontinue coverage while on leave. The SHBP will reinstate your coverage when you return from military service. However, for the time period allowed by the Veteran's Administration, the Plan does not cover care for a Participant's illness or injury that the Secretary of Veterans' Affairs determines was acquired or aggravated during the military leave.

Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA)

The Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and re-employment in regard to an Employee's military leave of absence. These requirements apply to medical and dental coverage for you and your Dependents. They do not apply to any Life, Short-term or Long-term Disability or Accidental Death & Dismemberment coverage you may have.

Continuation of Coverage

For leaves of less than 31 days, coverage will continue as described in the Termination section regarding Leave of Absence.

For leaves of 31 days or more, you may continue coverage for yourself and your Dependents as follows:

You may continue benefits by paying the required premium to SHBP, until the earliest of the following:

- 24 months from the last day of employment with the Employer;
- the day after you fail to return to work; and
- the date the policy cancels.

SHBP may charge you and your Dependents up to 102% of the total premium.

Reinstatement of Benefits (applicable to all coverages)

If your coverage ends during the leave of absence because you do not elect USERRA and you are reemployed by your current Employer, coverage for you and your Dependents may be reinstated if (a) you gave your Employer advance written or verbal notice of your military service leave, and (b) the duration of all military leaves while you are employed with your current Employer does not exceed 5 years.

You and your Dependents will be subject to only the balance of a Pre-Existing Condition Limitation (PCL) or waiting period that was not yet satisfied before the leave began. However, if an Injury or Sickness occurs or is aggravated during the military leave, full Plan limitations will apply.

Any 63-day break in coverage rule regarding credit for time accrued toward a PCL waiting period will be waived.

If your coverage under this plan terminates as a result of your eligibility for military medical and dental coverage and your order to active duty is canceled before your active duty service commences, these reinstatement rights will continue to apply.

FDRL58

COBRA Continuation Rights Under Federal Law

For You and Your Dependents

What is COBRA Continuation Coverage?

Under federal law, you and/or your Dependents must be given the opportunity to continue health insurance when there is a "qualifying event" that would result in loss of coverage under the Plan. You and/or your Dependents will be permitted to continue the same coverage under which you or your Dependents were covered on the day before the qualifying event occurred, unless you move out of that plan's coverage area or the plan is no longer available. You and/or your Dependents cannot change coverage options until the next open enrollment period.

When is COBRA Continuation Available?

For you and your Dependents, COBRA continuation is available for up to 18 months from the date of the following qualifying events if the event would result in a loss of coverage under the Plan:

- your termination of employment for any reason, other than gross misconduct, or
- your reduction in work hours.

For your Dependents, COBRA continuation coverage is available for up to 36 months from the date of the following qualifying events if the event would result in a loss of coverage under the Plan:

- your death;
- your divorce or legal separation; or
- for a Dependent child, failure to continue to qualify as a Dependent under the Plan.

Who is Entitled to COBRA Continuation?

Only a "qualified beneficiary" (as defined by federal law) may elect to continue health insurance coverage. A qualified beneficiary may include the following individuals who were covered by the Plan on the day the qualifying event occurred: you, your spouse, and your Dependent children. Each qualified beneficiary has their own right to elect or decline COBRA continuation coverage even if you decline or are not eligible for COBRA continuation.

The following individuals are not qualified beneficiaries for purposes of COBRA continuation: domestic partners, same sex spouses, grandchildren (unless adopted by you), stepchildren (unless adopted by you). Although these individuals do not have an independent right to elect COBRA continuation coverage, if you elect COBRA continuation coverage for yourself, you may also cover your covered Dependents even if they are not considered qualified beneficiaries under COBRA. However, such individuals' coverage will terminate when your COBRA continuation coverage terminates. The sections titled "Secondary Qualifying Events" and "Medicare Extension For Your Dependents" are not applicable to these individuals.

FDRL67

Secondary Qualifying Events

If, as a result of your termination of employment or reduction in work hours, your Dependent(s) have elected COBRA continuation coverage and one or more Dependents experience another COBRA qualifying event, the affected Dependent(s) may elect to extend their COBRA continuation coverage for an additional 18 months (7 months if the secondary event occurs within the disability extension period) for a maximum of 36 months from the initial qualifying event. The second qualifying event must occur before the end of the initial 18 months of COBRA continuation coverage or within the disability extension period discussed below. Under no circumstances will COBRA continuation coverage be available for more than 36 months from the initial qualifying event. Secondary qualifying events are: your death; your divorce or legal separation; or, for a Dependent child, failure to continue to qualify as a Dependent under the Plan.

Disability Extension

If, after electing COBRA continuation coverage due to your termination of employment or reduction in work hours, you or one of your Dependents is determined by the Social Security Administration (SSA) to be totally disabled under title II or XVI of the SSA, you and all of your Dependents who have elected COBRA continuation coverage may extend such continuation for an additional 11 months, for a maximum of 29 months from the initial qualifying event.

To qualify for the disability extension, all of the following requirements must be satisfied:

1. SSA must determine that the disability occurred prior to or within 60 days after the disabled individual elected COBRA continuation coverage; and
2. A copy of the written SSA determination must be provided to the Plan Administrator within 60 calendar days after the date the SSA determination is made AND before the end of the initial 18-month continuation period.

If the SSA later determines that the individual is no longer disabled, you must notify the Plan Administrator within 30 days after the date the final determination is made by SSA. The 11-month disability extension will terminate for all Covered Persons on the first day of the month that is more than 30 days after the date the SSA makes a final determination that the disabled individual is no longer disabled.

All causes for "Termination of COBRA Continuation" listed below will also apply to the period of disability extension.

Medicare Extension for Your Dependents

When the qualifying event is your termination of employment or reduction in work hours and you became enrolled in Medicare (Part A, Part B or both) within the 18 months before the qualifying event, COBRA continuation coverage for your Dependents will last for up to 36 months after the date you became enrolled in Medicare. Your COBRA continuation coverage will last for up to 18 months from the date of your termination of employment or reduction in work hours.

FDRL21

Termination of COBRA Continuation

COBRA continuation coverage will be terminated upon the occurrence of any of the following:

- the end of the COBRA continuation period of 18, 29 or 36 months, as applicable;
- failure to pay the required premium within 30 calendar days after the due date;
- cancellation of the Employer's policy with CIGNA;
- after electing COBRA continuation coverage, a qualified beneficiary enrolls in Medicare (Part A, Part B, or both);
- after electing COBRA continuation coverage, a qualified beneficiary becomes covered under another group health plan, unless the qualified beneficiary has a condition for which the new plan limits or excludes coverage under a pre-existing condition provision. In such case coverage will continue until the earliest of: (a) the end of the applicable maximum period; (b) the date the pre-existing condition provision is no longer applicable; or (c) the occurrence of a qualifying event described in one of the first three bullets above; or
- any reason the Plan would terminate coverage of a participant or beneficiary who is not receiving continuation coverage (e.g., fraud).

V1

Employer's Notification Requirements

Your Employer is required to provide you and/or your Dependents with the following notices:

- An initial notification of COBRA continuation rights must be provided within 90 days after your (or your spouse's) coverage under the Plan begins (or the Plan first becomes subject to COBRA continuation requirements, if later). If you and/or your Dependents experience a qualifying event before the end of that 90-day period, the initial notice must be provided within the time frame required for the COBRA continuation coverage election notice as explained below.

- A COBRA continuation coverage election notice must be provided to you and/or your Dependents within the following timeframes:

(a) if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the loss of coverage, 44 days after loss of coverage under the Plan;

(b) if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the occurrence of a qualifying event, 44 days after the qualifying event occurs; or

(c) in the case of a multi-employer plan, no later than 14 days after the end of the period in which Employers must provide notice of a qualifying event to the Plan Administrator.

How to Elect COBRA Continuation Coverage

The COBRA coverage election notice will list the individuals who are eligible for COBRA continuation coverage and inform you of the applicable premium. The notice will also include instructions for electing COBRA continuation coverage. You must notify the Plan Administrator of your election no later than the due date stated on the COBRA election notice. If a written election notice is required, it must be post-marked no later than the due date stated on the COBRA election notice. If you do not make proper notification by the due date shown on the notice, you and your Dependents will lose the right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed election form before the due date.

Each qualified beneficiary has an independent right to elect COBRA continuation coverage. Continuation coverage may be elected for only one, several, or for all Dependents who are qualified beneficiaries. Parents may elect to continue coverage on behalf of their Dependent children. You or your spouse may elect continuation coverage on behalf of all the qualified beneficiaries. You are not required to elect COBRA continuation coverage in order for your Dependents to elect COBRA continuation.

FDRL23

How Much Does COBRA Continuation Coverage Cost?

Each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount may not exceed 102% of the cost to the group health plan (including both Employer and Employee contributions) for coverage of a similarly situated active Employee or family member. The premium during the 11-month disability extension may not exceed 150% of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated active Employee or family member. For example:

If the Employee alone elects COBRA continuation coverage, the Employee will be charged 102% (or 150%) of the active Employee premium. If the spouse or one Dependent child alone elects COBRA continuation coverage, they will be charged 102% (or 150%) of the active Employee premium. If more than one qualified beneficiary elects COBRA continuation coverage, they will be charged 102% (or 150%) of the applicable coverage tier premium.

When and How to Pay COBRA Premiums

First payment for COBRA continuation

If you elect COBRA continuation coverage, you do not have to send any payment with the election form. However, you must make your first payment no later than 45 calendar days after the date of your election. (This is the date the Election Notice is postmarked, if mailed.) If you do not make your first payment within that 45 days, you will lose all COBRA continuation rights under the Plan.

Subsequent payments

After you make your first payment for COBRA continuation coverage, you will be required to make subsequent payments of the required premium for each additional month of coverage. Payment is due on the first day of each month. If you make a payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break.

Grace periods for subsequent payments

Although subsequent payments are due by the first day of the month, you will be given a grace period of 30 days after the first day of the coverage period to make each monthly payment. Your COBRA continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if your payment is received after the due date, your coverage under the Plan may be suspended during this time. Any providers who contact the Plan to confirm coverage during this time may be informed that coverage has been suspended. If payment is received before the end of the grace period, your coverage will be reinstated back to the beginning of the coverage period. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. If you fail to make a payment before the end of the grace period for that coverage period, you will lose all rights to COBRA continuation coverage under the Plan.

FDRL24 V2

You Must Give Notice of Certain Qualifying Events

If you or your Dependent(s) experience one of the following qualifying events, you must notify the Plan Administrator within 60 calendar days after the later of the date the qualifying event occurs or the date coverage would cease as a result of the qualifying event:

- Your divorce or legal separation;
- Your child ceases to qualify as a Dependent under the Plan; or
- The occurrence of a secondary qualifying event as discussed under “Secondary Qualifying Events” above (this notice must be received prior to the end of the initial 18- or 29-month COBRA period).

(Also refer to the section titled “Disability Extension” for additional notice requirements.)

Notice must be made in writing and must include: the name of the Plan, name and address of the Employee covered under the Plan, name and address(es) of the qualified beneficiaries affected by the qualifying event; the qualifying event; the date the qualifying event occurred; and supporting documentation (e.g., divorce decree, birth certificate, disability determination, etc.).

Newly Acquired Dependents

If you acquire a new Dependent through marriage, birth, adoption or placement for adoption while your coverage is being continued, you may cover such Dependent under your COBRA continuation coverage. However, only your newborn or adopted Dependent child is a qualified beneficiary and may continue COBRA continuation coverage for the remainder of the coverage period following your early termination of COBRA coverage or due to a secondary qualifying event. COBRA coverage for your Dependent spouse and any Dependent children who are not your children (e.g., stepchildren or grandchildren) will cease on the date your COBRA coverage ceases and they are not eligible for a secondary qualifying event.

COBRA Continuation for Retirees Following Employer’s Bankruptcy

If you are covered as a retiree, and a proceeding in bankruptcy is filed with respect to the Employer under Title 11 of the United States Code, you may be entitled to COBRA continuation coverage. If the bankruptcy results in a loss of coverage for you, your Dependents or your surviving spouse within one year before or after such proceeding, you and your covered Dependents will become COBRA qualified beneficiaries with respect to the bankruptcy. You will be entitled to COBRA continuation coverage until your death. Your surviving spouse and covered Dependent children will be entitled to COBRA continuation coverage for up to 36 months following your death. However, COBRA continuation coverage will cease upon the occurrence of any of the qualifying events listed under “Termination of COBRA Continuation” above.

FDRL25 V1

Trade Act of 2002

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired Employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or

get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TDD/TYY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp.

In addition, if you initially declined COBRA continuation coverage and, within 60 days after your loss of coverage under the Plan, you are deemed eligible by the U.S. Department of Labor or a state labor agency for trade adjustment assistance (TAA) benefits and the tax credit, you may be eligible for a special 60 day COBRA election period. The special election period begins on the first day of the month that you become TAA-eligible. If you elect COBRA coverage during this special election period, COBRA coverage will be effective on the first day of the special election period and will continue for 18 months, unless you experience one of the qualifying events discussed under "Termination of COBRA Continuation" above. Coverage will not be retroactive to the initial loss of coverage. If you receive a determination that you are TAA-eligible, you must notify the Plan Administrator immediately.

Interaction With Other Continuation Benefits

You may be eligible for other continuation benefits under state law. Refer to the Termination section for any other continuation benefits.

FDRL26

Important Notice from State Health Benefit Plan About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with State Health Benefit Plan and prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
2. **State Health Benefit Plan has determined that the prescription drug coverage offered by the State Health Benefit Plan is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered Creditable Coverage.**

Because your existing coverage, unless you are enrolled in the High Deductible Health Plan, is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage.

The SHBP has determined that the prescription drug coverage under the High Deductible Health Plan (HDHP) Option, is on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays and is considered Non-Creditable Coverage. **This is important because most likely you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage through the HDHP offered by SHBP.**

Individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from November 15th through December 31st. Beneficiaries leaving employer/union coverage may be eligible for a Special Enrollment Period to sign up for a Medicare prescription drug plan.

You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

FDRL52

If you have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see the Federal Requirements Section for more details.

NOT152

If you do decide to enroll in a Medicare prescription drug plan and drop your State Health Benefit Plan which includes prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

Please contact State Health Benefit Plan for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

You should also know that if you drop or lose your coverage with State Health Benefit Plan and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later.

If you go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to enroll.

For more information about this notice or your current prescription drug coverage…

Contact your Plan Administrator for further information. NOTE: You will receive this notice annually and at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage through State Health Benefit Plan changes. You also may request a copy.

For more information about your options under Medicare prescription drug coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. For more information about Medicare prescription drug plans:

- Visit www.medicare.gov.
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number) for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

FDRL53

For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at www.socialsecurity.gov, or you may call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.

Date:	May 20, 2009
Name of Entity/Sender:	State Health Benefit Plan
Contact--Position/Office:	Plan Administrator
Address:	2 Peachtree Street, 35th Floor
	Atlanta, GA 30303
Phone Number:	800-610-1863

FDRL54

When You Have a Complaint or an Appeal

For the purposes of this section, any reference to "you," "your," or "Member" also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted.

“Physician Reviewers” are licensed Physicians depending on the care, service or treatment under review.

We want you to be completely satisfied with the care you receive. That is why we have established a process for addressing your concerns and solving your problems.

Start With Member Services

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, or contractual benefits, you may call the toll-free number on your benefit Identification card, explanation of benefits, or claim form and explain your concern to one of our Member Services representatives. You may also express that concern in writing.

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 days. If you are not satisfied with the results of a coverage decision, you may start the appeals procedure.

Appeal Process – How to Appeal an Eligibility Decision

SHBP will handle all eligibility appeals. Please forward all requests for eligibility appeals along with a completed appeal form and supporting documentation to: State Health Benefit Plan, Membership Correspondence Unit, P. O. Box 1990, Atlanta, GA 30301-1990. The appeal forms are available through your Personnel/ Payroll office, website address **www.dch.ga.gov**, or directly from the SHBP. All Member correspondence sent to the Plan should include the enrolled member's Social Security Number (SSN) to prevent a delay in processing your request.

Appeals Procedure

CG has a two-step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request for an appeal in writing to CG within 365 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask CG to register your appeal by telephone. Call or write us at the toll-free number on your benefit Identification card, explanation of benefits, or claim form.

Level-One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

For level-one appeals, we will respond in writing with a decision within 15 calendar days after we receive an appeal for a required preservice or concurrent care coverage determination, and within 30 calendar days after we received an appeal for a postservice coverage determination. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum functionality or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay. CG's Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, CG will respond orally with a decision within 72 hours, followed up in writing.

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Level-Two Appeal

If you are dissatisfied with our level-one appeal decision, you may request a second review. To initiate a level-two appeal, follow the same process required for a level-one appeal.

Most requests for a second review will be conducted by the Committee, which consists of a minimum of three people. Anyone involved in the prior decision may not vote on the Committee. For appeals involving Medical Necessity or clinical appropriateness the Committee will consult with at least one Physician in the same or similar specialty as the care under consideration, as determined by CG's Physician reviewer. You may present your situation to the Committee in person or by conference call.

For level-two appeals we will acknowledge in writing that we have received your request and schedule a Committee review. For required preservice and concurrent care coverage determinations the Committee review will be completed within 15 calendar days and for post service claims, the Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. You will be notified in writing of the Committee's decision within 5 business days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum functionality or in the opinion of your Physician, would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay. CG's Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, CG will respond orally with a decision within 72 hours, followed up in writing.

Voluntary External Review Program

If a final determination to deny benefits is made, you may choose to participate in our voluntary external review program, at your cost. The cost can range from $500-$4,000. This program only applies if the decision is based on either of the following:

• Clinical reasons.

• The exclusion for Experimental, Investigational or Unproven Services.

NOTE: The external review program is not available if the coverage determinations are based on explicit benefit exclusions or defined benefit limits. Therefore, the second level appeal decision is final. Contact CIGNA at the telephone number shown on your ID card for more information on the voluntary external review program.

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific plan provisions on which the determination is based; (3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; (4) a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a); (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit.

You also have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the decision on review. You or your plan may have other voluntary alternative dispute resolution options such as Mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your State insurance regulatory agency. You may also contact the Plan Administrator.

Relevant Information

Relevant information is any document, record or other information which: (a) was relied upon in making the benefit determination; (b) was submitted, considered or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; (c) demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or (d) constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Legal Action

If your plan is governed by ERISA, you have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action against CG until you have completed the Level-One and Level-Two appeal processes. If your appeal is expedited, there is no need to complete the Level-Two process prior to bringing legal action.

FDRL40

Arbitration

To the extent permitted by law, any controversy between CG and the Group, or an insured (including any legal representative acting on behalf of a Member), arising out of or in connection with this Certificate may be submitted to arbitration upon written notice by one party to another. Such arbitration shall be governed by the provisions of the Commercial Arbitration Rules of the American Arbitration Association, to the extent that such provisions are not inconsistent with the provisions of this section.

If the parties cannot agree upon a single arbitrator within 30 days of the effective date of written notice of arbitration, each party shall choose one arbitrator within 15 working days after the expiration of such 30-day period and the two arbitrators so chosen shall choose a third arbitrator, who shall be an attorney duly licensed to practice law in the applicable state. If either party refuses or otherwise fails to choose an arbitrator within such 15-working-day-period, the arbitrator chosen shall choose a third arbitrator in accordance with these requirements.

The arbitration hearing shall be held within 30 days following appointment of the third arbitrator, unless otherwise agreed to by the parties. If either party refuses to or otherwise fails to participate in such arbitration hearing, such hearing shall proceed and shall be fully effective in accordance with this section, notwithstanding the absence of such party.

The arbitrator(s) shall render his (their) decision within 30 days after the termination of the arbitration hearing. To the extent permitted by law, the decision of the arbitrator, or the decision of any two arbitrators if there are three arbitrators, shall be binding upon both parties conclusive of the controversy in question, and enforceable in any court of competent jurisdiction.

No party to this Certificate shall have a right to cease performance of services or otherwise refuse to carry out its obligations under this Certificate pending the outcome of arbitration in accordance with this section, except as otherwise specifically provided under this Certificate.

FDRL41

Definitions

Active Service

You will be considered in Active Service:

- on any of your Employer's scheduled work days if you are performing the regular duties of your work on a full-time basis on that day either at your Employer's place of business or at some location to which you are required to travel for your Employer's business.
- on a day which is not one of your Employer's scheduled work days if you were in Active Service on the preceding scheduled work day.

DFS1

Bed and Board

The term Bed and Board includes all charges made by a Hospital on its own behalf for room and meals and for all general services and activities needed for the care of registered bed patients.

DFS14

Charges

The term "charges" means the actual billed charges; except when the provider has contracted directly or indirectly with CG for a different amount.

DFS940

Chiropractic Care

The term Chiropractic Care means the conservative management of neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain and improve function.

DFS1689

Custodial Services

Any services that are of a sheltering, protective, or safeguarding nature. Such services may include a stay in an institutional setting, at-home care, or nursing services to care for someone because of age or mental or physical condition. This service primarily helps the person in daily living. Custodial care also can provide medical services, given mainly to maintain the person’s current state of health. These services cannot be intended to greatly improve a medical condition; they are intended to provide care while the patient cannot care for himself or herself. Custodial Services include but are not limited to:

- Services related to watching or protecting a person;
- Services related to performing or assisting a person in performing any activities of daily living, such as: (a) walking, (b) grooming, (c) bathing, (d) dressing, (e) getting in or out of bed, (f) toileting, (g) eating, (h) preparing foods, or (i) taking medications that can be self administered, and
- Services not required to be performed by trained or skilled medical or paramedical personnel.

DFS1812

Dependent

Dependents are:

- your lawful spouse as defined by Georgia; and
- any unmarried child of yours who is:
  - less than 19 years old;
  - 19 years but less than 26 years old, enrolled in school as a full-time student and primarily supported by you;
  - 19 or more years old and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical handicap. Proof of the child's condition and dependence must be submitted to CG within 31 days after the date the child ceases to qualify above. During the next two years CG may, from time to time, require proof of the continuation of such condition and dependence. After that, CG may require proof no more than once a year.

A child includes a legally adopted child. It also includes a stepchild who lives with you.

Benefits for a Dependent child or student will continue until the last day of the calendar month in which the limiting age is reached.

Anyone who is eligible as an Employee will not be considered as a Dependent.

No one may be considered as a Dependent of more than one Employee.

DFS57

Emergency Services

Emergency services are medical, psychiatric, surgical, Hospital and related health care services and testing, including ambulance service, which are required to treat a sudden, unexpected onset of a bodily Injury or serious Sickness which could reasonably be expected by a prudent layperson to result in serious medical complications, loss of life or permanent impairment to bodily functions in the absence of immediate medical attention. Examples of emergency situations include uncontrolled bleeding, seizures or loss of consciousness, shortness of breath, chest pains or severe squeezing sensations in the chest, suspected overdose of medication or poisoning, sudden paralysis or slurred speech, burns, cuts and broken bones. The symptoms that led you to believe you needed emergency care, as coded by the provider and recorded by the Hospital on the UB92 claim form, or its successor, or the final diagnosis, whichever reasonably indicated an emergency medical condition, will be the basis for the determination of coverage, provided such symptoms reasonably indicate an emergency.

DFS1533

Employee

The term Employee means a full-time employee of the Employer who is currently in Active Service. The term does not include employees who are part-time or temporary or who normally work less than 30 hours a week for the Employer.

DFS1427

Employer

The term Employer means the plan sponsor self-insuring the benefits described in this booklet, on whose behalf CG is providing claim administration services.

DFS1595

Expense Incurred

An expense is incurred when the service or the supply for which it is incurred is provided.

DFS60

Free-Standing Surgical Facility

The term Free-standing Surgical Facility means an institution which meets all of the following requirements:

- it has a medical staff of Physicians, Nurses and licensed anesthesiologists;
- it maintains at least two operating rooms and one recovery room;
- it maintains diagnostic laboratory and x-ray facilities;
- it has equipment for emergency care;
- it has a blood supply;
- it maintains medical records;
- it has agreements with Hospitals for immediate acceptance of patients who need Hospital Confinement on an inpatient basis; and
- it is licensed in accordance with the laws of the appropriate legally authorized agency.

DFS682

Hospice Care Program

The term Hospice Care Program means:

- a coordinated, interdisciplinary program to meet the physical, psychological, spiritual and social needs of dying persons and their families;
- a program that provides palliative and supportive medical, nursing and other health services through home or inpatient care during the illness;
- a program for persons who have a Terminal Illness and for the families of those persons.

DFS70

Hospice Care Services

The term Hospice Care Services means any services provided by: (a) a Hospital, (b) a Skilled Nursing Facility or a similar institution, (c) a Home Health Care Agency, (d) a Hospice Facility, or (e) any other licensed facility or agency under a Hospice Care Program.

DFS599

Hospice Facility

The term Hospice Facility means an institution or part of it which:

- primarily provides care for Terminally Ill patients;
- is accredited by the National Hospice Organization;
- meets standards established by CG; and
- fulfills any licensing requirements of the state or locality in which it operates.

DFS72

Hospital

The term Hospital means:

- an institution licensed as a hospital, which: (a) maintains, on the premises, all facilities necessary for medical and surgical treatment; (b) provides such treatment on an inpatient basis, for compensation, under the supervision of Physicians; and (c) provides 24-hour service by Registered Graduate Nurses;
- an institution which qualifies as a hospital, a psychiatric hospital or a tuberculosis hospital, and a provider of services under Medicare, if such institution is accredited as a hospital by the Joint Commission on the Accreditation of Healthcare Organizations; or
- an institution which: (a) specializes in treatment of Mental Health and Substance Abuse or other related illness; (b) provides residential treatment programs; and (c) is licensed in accordance with the laws of the appropriate legally authorized agency.

The term Hospital will not include an institution which is primarily a place for rest, a place for the aged, or a nursing home.

DFS1693

Hospital Confinement or Confined in a Hospital

A person will be considered Confined in a Hospital if he is:

- a registered bed patient in a Hospital upon the recommendation of a Physician;
- receiving treatment for Mental Health and Substance Abuse Services in a Partial Hospitalization program;
- receiving treatment for Mental Health and Substance Abuse Services in a Mental Health or Substance Abuse Residential Treatment Center.

DFS1815

Injury

The term Injury means an accidental bodily injury.

DFS147

Maintenance Prescriptions

Prescription Drugs taken continuously to manage chronic or long-term conditions where Members respond positively to drug treatment, and dosage adjustments are either no longer required or are made infrequently.

Maintenance Treatment

The term Maintenance Treatment means treatment rendered to keep or maintain the patient's current status.

DFS1650

Maximum Reimbursable Charge - Medical

The Maximum Reimbursable Charge for covered services is determined based on the lesser of:

- the provider’s normal charge for a similar service or supply; or
- a policyholder-selected percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by CG.

The percentile used to determine the Maximum Reimbursable Charge is listed in The Schedule.

The Maximum Reimbursable Charge is subject to all other benefit limitations and applicable coding and payment methodologies determined by CG. Additional information about how CG determines the Maximum Reimbursable Charge is available upon request.

GM6000 DFS1997V5

Medicaid

The term Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

DFS192

Medically Necessary/Medical Necessity

Medically Necessary Covered Services and Supplies are those determined by the Medical Director to be:

- required to diagnose or treat an illness, injury, disease or its symptoms;
- in accordance with generally accepted standards of medical practice;
- clinically appropriate in terms of type, frequency, extent, site and duration;
- not primarily for the convenience of the patient, Physician or other health care provider; and
- rendered in the least intensive setting that is appropriate for the delivery of the services and supplies. Where applicable, the Medical Director may compare the cost-effectiveness of alternative services, settings or supplies when determining least intensive setting.

DFS1813

Medicare

The term Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.

DFS149

Necessary Services and Supplies

The term Necessary Services and Supplies includes:

- any charges, except charges for Bed and Board, made by a Hospital on its own behalf for medical services and supplies actually used during Hospital Confinement;
- any charges, by whomever made, for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided; and
- any charges, by whomever made, for the administration of anesthetics during Hospital Confinement.

The term Necessary Services and Supplies will not include any charges for special nursing fees, dental fees or medical fees.

DFS151

Nurse

The term Nurse means a Registered Graduate Nurse, a Licensed Practical Nurse or a Licensed Vocational Nurse who has the right to use the abbreviation "R.N.," "L.P.N." or "L.V.N."

DFS155

Other Health Care Facility

The term Other Health Care Facility means a facility other than a Hospital or hospice facility. Examples of Other Health Care Facilities include, but are not limited to, licensed skilled nursing facilities, rehabilitation Hospitals and subacute facilities.

DFS1686

Other Health Professional

The term Other Health Professional means an individual other than a Physician who is licensed or otherwise authorized under the applicable state law to deliver medical services and supplies. Other Health Professionals include, but are not limited to physical therapists, registered nurses and licensed practical nurses.

DFS1685

Participating Pharmacy

The term Participating Pharmacy means a retail pharmacy with which Connecticut General Life Insurance Company has contracted to provide prescription services to insureds.

DFS1937

Participating Provider

The term Participating Provider means a hospital, a Physician or any other health care practitioner or entity that has a direct or indirect contractual arrangement with CIGNA to provide covered services with regard to a particular plan under which the participant is covered.

DFS1910

Pharmacy

The term Pharmacy means a retail pharmacy.

DFS1934

Pharmacy & Therapeutics (P & T) Committee

A committee of CG Participating Providers, Medical Directors and Pharmacy Directors which regularly reviews Prescription Drugs and Related Supplies for safety and efficacy. The P&T Committee evaluates Prescription Drugs and Related Supplies for potential addition to or deletion from the Prescription Drug List and may also set dosage and/or dispensing limits on Prescription Drugs and Related Supplies.

DFS1919

Physician

The term Physician means a licensed medical practitioner who is practicing within the scope of his license and who is licensed to prescribe and administer drugs or to perform surgery. It will also include any other licensed medical practitioner whose services are required to be covered by law in the locality where the policy is issued if he is:

- operating within the scope of his license; and
- performing a service for which benefits are provided under this plan when performed by a Physician.

DFS164

Prescription Drug

Prescription Drug means; (a) a drug which has been approved by the Food and Drug Administration for safety and efficacy; (b) certain drugs approved under the Drug Efficacy Study Implementation review; or (c) drugs marketed prior to 1938 and not subject to review, and which can, under federal or state law, be dispensed only pursuant to a Prescription Order.

DFS1708

Prescription Drug List

Prescription Drug List means a listing of approved Prescription Drugs and Related Supplies. The Prescription Drugs and Related Supplies included in the Prescription Drug List have been approved in accordance with parameters established by the P&T Committee. The Prescription Drug List is regularly reviewed and updated.

DFS1924

Prescription Order

Prescription Order means the lawful authorization for a Prescription Drug or Related Supply by a Physician who is duly licensed to make such authorization within the course of such Physician's professional practice or each authorized refill thereof.

DFS1711

Preventive Treatment

The term Preventive Treatment means treatment rendered to prevent disease or it’s recurrence. This is typically defined as:

- periodic health evaluations, such as annual physicals and well-child care;
- child and adult immunizations; and
- screening services.

DFS1652

Primary Care Physician

The term Primary Care Physician means a Physician: (a) who qualifies as a Participating Provider in general practice, internal medicine, family practice or pediatrics; and (b) who has been selected by you, as authorized by the Provider Organization, to provide or arrange for medical care for you or any of your insured Dependents.

DFS622

Psychologist

The term Psychologist means a person who is licensed or certified as a clinical psychologist. Where no licensure or certification exists, the term Psychologist means a person who is considered qualified as a clinical psychologist by a recognized psychological association. It will also include any other licensed counseling practitioner whose services are required to be covered by law in the locality where the policy is issued if he is:

- operating within the scope of his license; and
- performing a service for which benefits are provided under this plan when performed by a Psychologist.

DFS170

Related Supplies

Related Supplies means diabetic supplies (insulin needles and syringes, lancets and glucose test strips), needles and syringes for injectables covered under the pharmacy plan, and spacers for use with oral inhalers.

DFS1710

Review Organization

The term Review Organization refers to an affiliate of CG or another entity to which CG has delegated responsibility for performing utilization review services. The Review Organization is an organization with a staff of clinicians which may include Physicians, Registered Graduate Nurses, licensed mental health and substance abuse professionals, and other trained staff Members who perform utilization review services.

DFS1688

Sickness – For Medical Insurance

The term Sickness means a physical or mental illness. It also includes pregnancy. Expenses incurred for routine Hospital and pediatric care of a newborn child prior to discharge from the Hospital nursery will be considered to be incurred as a result of Sickness.

DFS531

Skilled Nursing Facility

The term Skilled Nursing Facility means a licensed institution (other than a Hospital, as defined) which specializes in:

- physical rehabilitation on an inpatient basis; or
- skilled nursing and medical care on an inpatient basis;

but only if that institution: (a) maintains on the premises all facilities necessary for medical treatment; (b) provides such treatment, for compensation, under the supervision of Physicians; and (c) provides Nurses' services.

DFS193

Terminal Illness

A Terminal Illness will be considered to exist if a person becomes terminally ill with a prognosis of six months or less to live, as diagnosed by a Physician.

DFS197

Urgent Care

Urgent Care is medical, surgical, Hospital or related health care services and testing which are not Emergency Services, but which are determined by CG, in accordance with generally accepted medical standards, to have been necessary to treat a condition requiring prompt medical attention. This does not include care that could have been foreseen before leaving the immediate area where you ordinarily receive and/or were scheduled to receive services. Such care includes, but is not limited to, dialysis, scheduled medical treatments or therapy, or care received after a Physician's recommendation that the insured should not travel due to any medical condition.

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